Balance Massage & Spa – Therapy Wellness Chart

Name: _____ Address: _____

Cell Phone: _____ City: _____

Email Address: _____ State & Zip: _____

Welcome to Balance Massage & Spa. We are delighter you have chosen our massage therapy services. Balance Massage only employs licensed, professional massage therapists. If requested, proof of your therapist's license will be provided to you. Male and female genitalia and women's breasts will not be exposed or massaged at any time and modest draping will be used during the session. If you feel uncomfortable for any reason, ask your therapist to end the session.

It is your responsibility to inform the therapist of any pre-existing conditions, limitations, or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you feel any discomfort, please ask your therapist to adjust the heaat or pressure to your comfort level. You understand and voluntarily accept any risks of which you have been advised about associated with your massage, and with use of the facilities, and hereby release Balance Massage & Spa from all liability for any injury, including, without limitation, personal, bodily, or mental injury, economic loss, or any damage resulting to you there from. You further hereby release all of the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that is in unsafe for you to proceed with or continue a therapeutic session due to health related concerns. In this event, you may be required to provide Balance Massage & Spa with a physician's medical release prior to continuing treatment.

The undersigned acknowledges that he/she has read this agreement.

Signature: _____ Date: _____

Are you comfortable with having therapeutic massage on the following areas:

Gluteal Region: Y ____ N ____ Pectorals: Y ____ N ____ Feet: Y ____ N ____ Face/Head: Y ____ N ____

Desired Pressure: Light ____ Firm ____ Deep ____

Have you ever experience massage therapy before? Y ____ N ____

Please help us ensure a safe and comfortable massage experience by providing the following information. Check all that apply and explain below:

- o Blood Clots
- o Cancer
- o Diabetes
- o Fibromyalgia/Lupus
- o Headaches
- o Heart Problems
- o High/Low Blood Pressure
- o History of Strokes
- o Immune System Deficiencies
- o Infections
- o Insomnia
- o Osteoarthritis
- o Osteoporosis
- o Pain (Joint, Muscle, Disc, Nerve)
- o Rheumatoid Arthritis
- o Thyroid Issues
- o Varicose Veins

Explanations: _____

_____

List and explain: Surgeries, injuries, illnesses _____

List all medications: _____

Have you experienced any of the following in the past three month: pain, numbness, tingling, swelling, fatigue, etc?

If yes, please explain: _____

_____

List daily activites that are inhibited by your current conditions: _____