

JASPERS ORGANIC DAY SPA

client intake form

personal information

name date of birth

address

postcode mobile

sex m f other email

health information ~ please tick all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> smoker | <input type="checkbox"/> blood clots, dvt | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> sunburn | <input type="checkbox"/> dizziness | <input type="checkbox"/> musculoskeletal |
| <input type="checkbox"/> headache | <input type="checkbox"/> back pain, sciatica | <input type="checkbox"/> allergies, rashes |
| <input type="checkbox"/> asthma | <input type="checkbox"/> constipation, diarrhoea | <input type="checkbox"/> cold or flu |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> diseases | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> recent surgery | <input type="checkbox"/> stomach problems, ulcer, digestion |
| <input type="checkbox"/> depression | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> pins, pacemaker |
| <input type="checkbox"/> haemophilia | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> cuts, burns, bruises | <input type="checkbox"/> inflammation | <input type="checkbox"/> hiv |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> pregnant | <input type="checkbox"/> athletes foot |
| <input type="checkbox"/> arteriosclerosis | <input type="checkbox"/> hernia | <input type="checkbox"/> visually and/or hearing impaired |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> cancer | <input type="checkbox"/> contact lenses |

advise of any other health issues we should know about

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.....
.....

list any medications you are on

.....
.....
.....

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is this your first massage yes no

is there any part of your body you do not like to be touched or massaged

.....

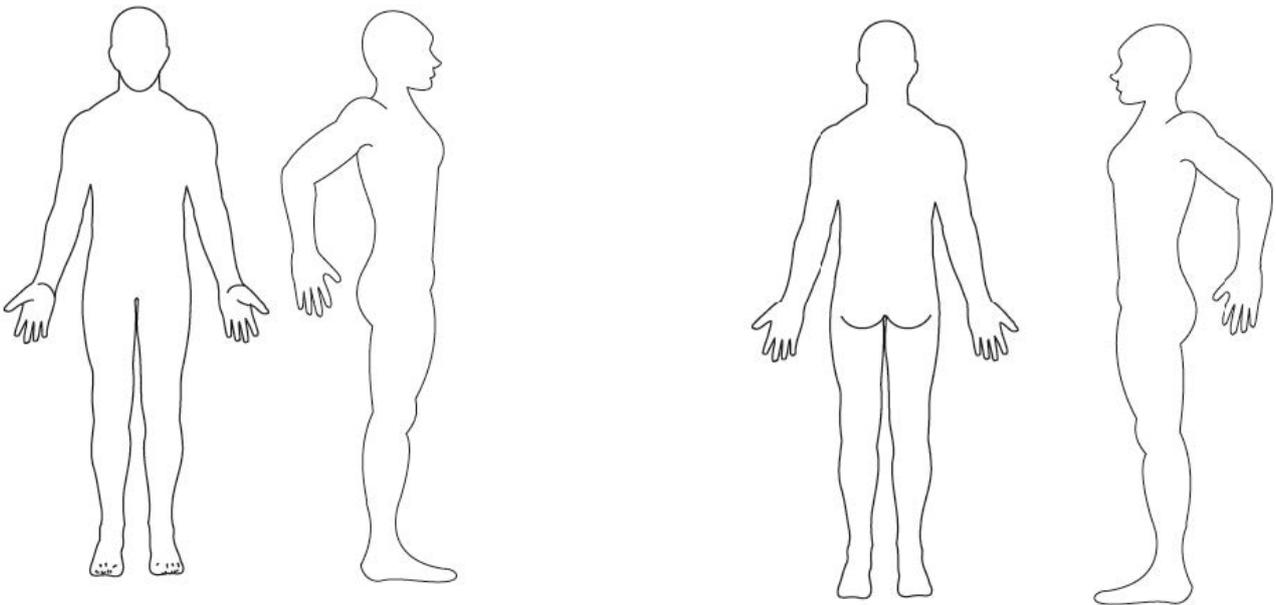
.....

what is the primary purpose of your visit today

pain relief relaxation therapeutic other

.....

please mark areas of discomfort



consent fo treatment

I understand that massage practitioners do not diagnose illnesses, diseases or any physical or mental disorders, nor do they prescribe medical treatments or perform spinal manipulations. I acknowledge that a massage is not a substitute for a medical examination or diganosis and it is recommended that I see a primary health care provider for that service.

I have stated all known medical conditions and will take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session. I will advise the therapist of any perceived changes resulting from my massage therapy as soon as I become aware of them.

I understand that no sexual activities, comment or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action etc. without explanation or prior notice and I agree to this policy.

24 hours notice is required if you wish to change or cancel your scheduled appointment. A 100% charge will apply for any treatments cancelled with less than 24 hours notice. This cancellation policy also applies for no shows.

date

signature

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