BELLE ROSS SPA & SALON
CONFIDENTIAL CLIENT INFORMATION FORM- PLEASE PRINT

Name:_____D.O.B:_____Email:_____

Address:_____City:_____ST:_____Zip:_____

Phone: (Home)(_____)_____(Work)(_____)_____(Cell)(_____)_____

Employer:_____Occupation:_____

Emergency Contact Person:_____Phone:_____

Referred by:_____

Previous Experience with Massage:_____

Date of Last Massage:_____

Primary Reason for Appointment/Areas of Pain or Tension:_____

_____

Because massage has both physical and mental/emotional affects it is important to keep the massage therapist aware of your health status. Are you currently seeing a health care provider? NO_____ YES_____

Permission to contact health care provider or massage therapist/physical therapist/ occupational therapist/ chiropractor

Physician:_____Phone:_____Initial for Permission:_____

Therapist:_____Phone:_____Initial for Permission:_____

Please mark (X) to all conditions that apply now. Put a P for past conditions. Put F for family history of illness.

___ Headaches, Migraines	___ Chronic Pain	___ Fatigue
___Vision Problems, Contact Lenses	___ Muscle or Joint Pain	___ Tension, Stress
___ Hearing Problems, Deafness	___ Muscle, Bone Injuries	___ Depression
___ Injuries to face or head	___ Numbness or Tingling	___ Sleep Difficulties
___Sinus Problems	___ Sprains, Strains	___ Allergies, Sensitivity
___ Dental Bridges, Braces	___ Arthritis, Tendonitis	___ Rash, Athletes Foot
___ Jaw Pain, TMJ Problems	___ Cancer, Tumors	___ Infectious Disease
___ Asthma or Lung Conditions	___ Spinal Column Disorders	___ Blood Clots
___ Hernia (Hiatal/Inguinal)	___ Diabetes	___ Varicose Veins
___ Constipation/Diarrhea	___ Pregnancy (Trimester:_____)	___High/Low Blood Pressure
___ Congestive Heart Failure	___ Skin Disorders	___ Other (_____)

Current medications, including asprin, ibuprofen, herbs, vitamins, etc:_____

_____

Surgeries:_____

Accidents:_____

Please list all forms and frequency of stress-reductions activities, hobbies, exercise, or sports participation:

_____

Please read the following statements and sign below

- I understand this massage is NOT a replacement for medical care.
- I have disclosed any conditions that massage therapy may aggravate.
- I understand that any illicit or sexually suggestive remarks or advances made by me or you will result in immediate termination of the session, and I or you will be liable for payment for the full scheduled session.
- My session may be abbreviated if I did not arrive at scheduled time

Client Signature:_____Date:_____

Therapist Signature:_____Date:_____