CLIENT HISTORY INFORMATION

Zardus Art of Massage & Wellness Spa, Corp.
1 Lincoln Ave, Gardiner ME 04345
info@zardusartofmassage.com / 207-446-7470

Name: _____Date of Birth:_____

Mailing Address:_____

Phone Numbers: _____

Email Address:_____ OK to use email for appointment confirmation, new spa offerings, spa promotions and upcoming spa events ❑ yes ❑ no

Occupation:_____

Physicians Name and Phone_____ Approval to contact: ❑yes ❑no

Emergency Contact Name and Phone:_____

Referred by:_____

Have you had professional massage before? ❑yes ❑no Date of last massage: _____

List stress reduction activities, and frequency:_____

Describe any major diagnoses / conditions and chronic / ongoing pain location & pain level:

_____

_____

_____

_____

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_____

List any allergies/sensitivities to scents, oils, herbs, nuts or touch:

_____

_____

_____

_____

Check all that apply to your current health:

❑Pregnancy
❑Diabetes
❑Heart Condition
❑Circulatory Condition
❑Blood Clots
❑Cancer
❑Infection
❑Breathing difficulty
❑Arthritis
❑Tendonitis

❑Rashes
❑Athlete's foot
❑Warts
❑Fibromyalgia or Chronic Fatigue Syndrome
❑High/low blood pressure
❑Spinal injury/surgery
❑Headaches
❑Varicose Veins
❑Osteoporosis
❑HIV/AIDS

Is there anything else your massage therapist should know? Please explain.

It is my choice to receive massage therapy. I agree to communicate with my practitioner any time I feel as if my well-being is being compromised. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal or skeletal manipulations.

I understand that any illicit or sexually suggestive remarks or advances made by me, the client will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health.

Client Signature:_____ Date:_____

CONSENT TO TREATMENT OF MINOR: I hereby authorize the above-named l to administer massage/bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian:_____ Date: _____