



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Practitioner's Initials: _____

General Information

First Name: _____ Last Name: _____ Date of Birth: ___/___/___

Address: _____ Apt: _____ City: _____ Zip: _____ Male **OR** Female

Phone: (Cell) (_____) _____ Cell Service Provider: _____ (ex: AT&T)

Email: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: (_____) _____

Relationship: _____ Who Referred You? **Name:** _____

Groupon Redemption Code

(8-digit number OR beginning in NY1 OR NY2)

____/____/____/____/____/____/____/____

Enhance Your Session with One of the Following

Prices	Add-on Services	Benefits	✓
\$10	Sugar Foot Scrub	Soothe tired feet and alleviate dry skin to refresh, revive and reveal a healthy glow.	
\$35	Herbal Steam Detox <i>(Requires additional 25 min)</i>	Helps with: Skin care, cellulite reduction, deep relaxation, joint pain relief and detox.	
\$10	Hand/ Foot Paraffin	Soothes and repairs cracked and dry skin, while moisturizing your hands or feet.	
\$10	Aroma Therapy	Relieve stress, inflammation, and pain with essential oils from herbs, flowers and fruits.	

COMPLETE OTHER SIDE 



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Medical Background

1. Is this your first professional massage? ___ Yes ___ No	10. Area(s) you would like your therapist to avoid : _____
2. If no, how frequently do you get massage? _____	11. Area(s) you would like your therapist to focus on: _____
3. What do you hope to accomplish from today's massage? _____	12. Pressure Preferred: (Circle one) Light Medium Firm
4. Are you aware of any tension holding spots in your body? ___ Yes ___ No If yes, where: _____	13. 1-5 with 5 being the most what is your pain level today? _____
5. Do you have any sensitivity to heat or cold? ___ Yes ___ No	14. 1-5 with 5 being the most what is your stress level today? _____
6. Do you have any allergies or sensitivity to smells, oils, lotions, or ointments? ___ Yes ___ No	15. Are you Pregnant? ___ Yes ___ No How many months? _____
7. Do you have any skin conditions or rashes? ___ Yes ___ No	16. Do you have any difficulty lying on your front, back or side? ___ Yes ___ No
8. Any recent surgeries or broken bones? ___ Yes ___ No If yes, what kind or where: _____	17. Do you see a chiropractor? ___ Yes ___ No
9. Do you have any chronic, ongoing pain that you deal with on a regular basis? ___ Yes ___ No	18. Do you wear contact lenses? ___ Yes ___ No

I, the undersigned patient, understands, acknowledges and agrees that: (i) I am aware the facilities and services offered by Somatic Massage Therapy, P.C. involves risk. (ii) I have provided all relevant information regarding my current health status. (iii) I am seeking the Spa/Medical Massage services at my own free will; and (iv) I assume all risk associated therewith. On behalf of myself and my heirs I hereby release and discharge Somatic Massage Therapy, P.C. (the "Owner") and all of their affiliates, employees, contractors, directors, officers, agents, landlords, representatives, successors and assigns of the owner from any and all claims or causes of actions arising out of or relating to spa services. Including but not limited to, those resulting from bodily injury, theft, loss of, or damage to property of mine unless due to the gross negligence of willful misconduct of Somatic Massage Therapy, P.C., It's owner or employees/contractors.

I, further, fully understand, acknowledge and agree all spa services, are provided exclusive as a convenience to me by Somatic Massage Therapy, P.C. and I accept the service(s) at my own risk and expense without liability or responsibility to the Spa or its affiliates.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours' notice (medical emergencies excluded) will be charged 50% and complete NO-SHOW will be charged 100%.

Signature: _____ Date: _____