Today's Date: _____

RenewU Day Spa Client Intake Form

Full Name: _____ Email: _____

Address: _____ (city/state/zip)_____

Phone: (cell) _____ (home) _____ (work) _____

DOB:____/____/____ Height: _____ Weight: _____ Marital Status: ____Anniversary:____/____/____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Physician: _____ Phone #: _____

Have you had a professional massage or body treatment before? _____yes_____no

What are your hobbies? _____

Medical History:

How would you describe your overall health? (circle one) poor fair good excellent

How often do you use the following? (how much)

_____ Caffeine _____ Nicotine _____ Alcohol _____ Fast Food _____ Water

Medications: _____

_____

_____

Herbs, Vitamins or Supplements: _____

_____

Have you had any injuries or surgeries: _____ yes _____ no If yes, please describe:_____

_____

_____

Do you have any sleep disorders? Such as: sleep apnea, narcolepsy, etc. ____ yes _____ no

Do you wear: Contacts ____ yes ____no Hearing aids ____ yes ____no Dentures ____yes ____no

Have you been told not to use a Sauna, Steam Room or Hot Tub? _____yes _____no

Do you have any artificial joints, pins, plates, etc.? _____ yes _____ no

If yes, where on body: _____

Do you have any computer implants such as a pacemaker, insulin pump or spinal stimulator? __y __n

If yes, what type and when implanted: _____

Please indicate any of the following conditions that you currently have or have had:

□ high blood pressure	□ headaches	□ neck/back injury
□ low blood pressure	□ migraine headaches	□ low back pain
□ heart disease	□ insomnia	□ joint surgery/disease
□ stroke	□ digestive problems	□ skeletal injuries
□ seizures	□ IBS	□ sprain/strain
□ chest pain	□ diverticulitis	□ recent injury
□ numbness	□ constipation	□ PMS
□ dizziness	□ abdominal pain	□ fibromyalgia
□ depression	□ skin conditions	□ fibroid tumors
□ blood clots	□ TMJ	□ tumors/cysts
□ varicose/spider veins	□ hernia/rupture	□ cancer (type/where)
□ circulatory disorders	□ scoliosis	□ allergies
□ phlebitis	□ arthritis/tendonitis	□ asthma
□ breathing difficulties	□ osteoporosis	□ diabetes
□ sinus problems	□ neck pain/whiplash	□ other

Please explain any conditions you marked above: _____

_____

Are you pregnant? _____ yes _____ no If yes, please fill out the bottom of the next sheet.

Is there anything else that I/we should know prior to your treatment? _____

_____

What are your goals for today's session? _____

Draping: Louisiana Law requires keeping the unclothed body properly draped at all times. This is necessary for your warmth and sense of ease, as well as a mark of professionalism.

Release and Consent: I understand that the massage bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session or prior to receiving massage in the future, I will immediately inform the practitioner so that the pressure and/or stroke may be adjusted to my level of comfort. I also am aware that if cupping is used that there is a possibility of skin discoloration or "Cup Kiss" appearing as tissue is released. I understand that a "Cup Kiss" is not a bruise and that it will dissipate within a few hours to a few days. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so. For severe medical conditions, the practitioner may require a physician's release. I t is also understood that any illicit or sexually suggested remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I agree to pay the full amount for any scheduled massage if I don't give at least a four hour notice of cancellation. Understanding all of the above I hereby freely give my permission to be massaged.

Signature: _____ Date: _____

Parent/Guardian Signature and consent if under 18: _____

*****PREGNANCY ONLY***:**

Is this your first pregnancy? ___yes ___no If no, how many children do you have? _____

Have you had any miscarriages? ___ yes ___no Have you had multiple births? ___ yes ___no

How far along are you in your pregnancy? _____ Any complications? _____

Are you experiencing any areas of discomfort? ___yes ___no If yes, where? _____

Are you experiencing any of the following?

□ heart burn	□ pre-eclampsia	□ abdominal pain
□ high blood pressure	□ low blood pressure	□ varicose veins
□ vaginal discharge	□ diabetes	□ deep vein thrombosis

Who is your primary care provider? _____

Address: _____ Phone#: _____

Is it O. K. for me to consult with him/her about your pregnancy? _____yes _____no

Is there any other medical information that I should know before proceeding with your massage? _____

_____

I am having a normal pregnancy and hereby give permission to be massaged without any medical diagnosis.

Signature: _____ Date: _____