

KaLis Day Spa – Massage Treatments

Name: _____ Date: _____

Address: _____

Cell Phone #: _____ Home Phone #: _____

Occupation: _____ D.O.B.: _____

Email: _____ Referred By: _____

Have you had any P.T, Massage Therapy, or Chiropractic Care this year? Yes No

When was your last session? _____

What is your major concern? _____

Are you exercising regularly? Yes No If yes, how often? _____

What kind of exercise? _____

Do you smoke? Yes No If yes, how often? _____

Do you have any, or have you had any of the following (please check):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hernia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Pins or Plates | <input type="checkbox"/> Depression | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Muscular Prob. | <input type="checkbox"/> High Blood Pres. | <input type="checkbox"/> Bruising Easy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Neck, Back etc. | <input type="checkbox"/> Low Blood Pres. | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> AIDS |

Other problems not listed? _____

Any illnesses or operations? _____

What medication are you currently taking? _____

Please list any allergies you might have? _____

Are you currently wearing contact lenses? Yes No

WOMEN ONLY:

Are you pregnant? Yes No If yes, how many weeks? _____

Signature _____ Date _____

Release Form

I understand that the massage / body work I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and / or strokes may be adjusted to my level of comfort.

I further understand that massage / body work should not be construed as 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.

Because massage / body work is contraindicated (should not be done) 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 practitioner's part should I forget to do so.

Signature _____ Date _____

Practitioner _____ Date _____