

**TOM MARCHANT'S MASSAGE & BODY SPA**

**(469) 449-5727**

**INITIAL CONSULTATION FORM**

First Name: \_\_\_\_\_ Mi. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (Cell) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_ Email Address? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Reasons/Goals for this visit: \_\_\_\_\_

You are scheduled for what type of treatment(s) today? \_\_\_\_\_

Have you had this treatment(s) before? . Yes . No If yes, how long ago? \_\_\_\_\_

Please list any allergies, injuries, illnesses, surgeries, and health concerns you have now or had recently: \_\_\_\_\_

List typical daily activities - work, exercise, home: \_\_\_\_\_

Please **check** any of the following conditions you have.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neck/Spine Injury           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Ailment  |
| <input type="checkbox"/> Back Pain                   | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Kidney Ailment |
| <input type="checkbox"/> Sciatica/Leg Pain           | <input type="checkbox"/> Skin Disorders      | <input type="checkbox"/> Heart Ailment  |
| <input type="checkbox"/> Carpal Tunnel               | <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> Fibromyalgia   |
| <input type="checkbox"/> TMJ Syndrome                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Varicose Veins              | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> PMS Syndrome   |
| <input type="checkbox"/> Sensitivity to Iodine       | <input type="checkbox"/> Cold/Flu/Fever      | <input type="checkbox"/> Grief Process  |
| <input type="checkbox"/> Sensitivity to heat or cold | <input type="checkbox"/> Sport Injuries      | <input type="checkbox"/> Headache       |
| <input type="checkbox"/> Sensitivity to scents       | <input type="checkbox"/> Pregnancy           | Other _____                             |

Are you currently under the care of a physician? \_\_\_\_\_ If "Yes" whom? \_\_\_\_\_

Please list reason(s): \_\_\_\_\_

Describe your general Health: \_\_\_\_\_

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The parts of the body that will be worked or the areas of the body that will be avoided are to be marked on the diagram on the right. **Circled** are the areas of the body that need the **most** attention, and an **"X"** are over the areas that are to be avoided.



Contraindications are listed below:

**Information and Suggestions**

- Prior to your spa treatment, please remove all jewelry. Pull long hair back with a clip.
- As a rule, spa treatments are given while you are unclothed. Modesty and comfort levels vary from person to person. You may choose to wear undergarments or a swim suit or nothing at all. This is YOUR spa treatment and you should feel as comfortable as possible.
- Feel free to ask your practitioner any questions about the procedure. Your practitioner is a highly trained professional and will be happy to make you feel well informed and comfortable.
- Massage is indicated for stress reduction, relief from muscle tension or spasm and to increase the flow of circulation.

**PLEASE INITIAL THE FOLLOWING STATEMENTS:**

**Initial**

1. I am aware that draping will be used during the spa treatment, unless otherwise agreed to by me and my practitioner. \_\_\_\_\_

\_\_\_ I prefer draping over my body

\_\_\_ I prefer no draping over my body

2. I understand that my practitioner will not massage my breasts without my written consent. \_\_\_\_\_

I *give* / *do not give* consent for breast massage

3. I understand that my feedback is an essential element in my treatment; therefore for any reason should I become uncomfortable, I may bring it to my practitioner's attention and request that the session end. \_\_\_\_\_

The following type(s) of massage techniques will be used in the spa treatment session.

\_\_\_ Myofascial    \_\_\_ Pregnancy    \_\_\_ Swedish    \_\_\_ Stretching    \_\_\_ Sports    \_\_\_ Trigger Point

**PLEASE READ THE FOLLOWING AND THEN SIGN BELOW**

It is my choice to receive this spa treatment, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I acknowledge that spa treatments are not a substitute for medical diagnosis and treatment.

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Practitioner Signature**

\_\_\_\_\_  
**Date**