Inis Spa Data Profile
Confidential Information

Welcome! I want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let me know.

[PLEASE PRINT]

Date: _____ Local Resident or Visiting the Area? _____

Name:_____ Phone (H) _____ (C) _____

Street: _____ City _____ State _____ Zip _____

Date of Birth _____ Under 21 21-30 31-40 41-50 Over 50 □ Male □ Female

Marital Status S M Referred By _____

E-Mail Address
_____

Would you like to receive our Monthly Newsletter and Specials through your email? □ Yes □ No

- I understand that treatments at Inis Spa are not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours or failure to show for an appointment.
- Being that treatments should not be done under certain medical conditions, my therapist has the right to refuse this treatment.

Signature _____ Date_____

Inis Spa
mind. Body. Spirit of the Island.

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

General and Medical Information:

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to pressure/touch anywhere (ticklish)? _____

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

_____

List of current medications and reason for taking: _____

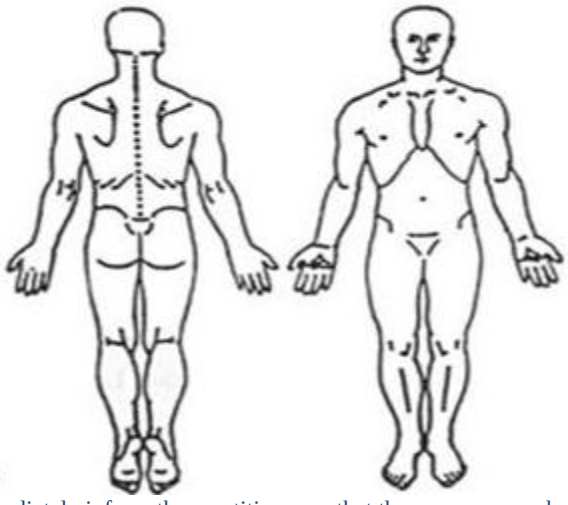
_____

Any topical medications (ointments or creams): Y N _____

List of surgeries, if any (type and date) or recent injuries: _____

Please check all that apply:

- Skin condition, rash, wart, hives, skin cancer, Other:_____
- Lymphatic condition, swollen gland, nasal congestion, lymph edema
- Joint problem/stiffness, arthritis, sacroiliac problem, TMJ, other_____
- Bone condition, osteoporosis, fracture
- Headaches
- Recent injury or accident, whiplash, sprain, bruise, other _____
- Circulatory issue, high/low blood pressure, Varicose veins, blood clots
- Numbness/Tingling, sciatica
- Tendonitis, bursitis
- Diabetes



Indicate Areas of Pain Tension:

On a scale of 1-10, 10=highest, rate you levels of:

Stress: _____ Pain: _____ Energy: _____

How did your symptoms begin? When did they start?

_____

_____

Is the condition getting better/worse? _____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my comfort. I further understand that massage should not be construed as a substitute for medical examination or diagnosis. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____