

A Borgata Salon & Spa

Consultation / Consent Form

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone #: _____ E-Mail: _____ @ _____

We use your email address to send you Appointment Reminders, Thank You emails and occasional Specials that the Spa offers. If you prefer not to receive our emails, please leave this entry blank.

Health History:

Massage Services

Have you ever had a massage before? _____ When was your last massage? _____

Are you pregnant? _____ If YES, How far along are you? _____

Have you had **surgery** & what for? _____

Do you have any allergies to oils, lotions? _____

Have you suffered from the following: (Please indicate Current (C) or Past (P))

Arthritis	Fatigue	Kidney Problems	Skin Disorders
Bladder Problems	Fever	Knee Problems	Tinnitus
Colds	Heart Issues	Liver Conditions	Ulcers
Depression	Heart Burn	Neck Problems	Blood Pressure
Dizziness	Insomnia	Phlebitis	Headache/Migraine

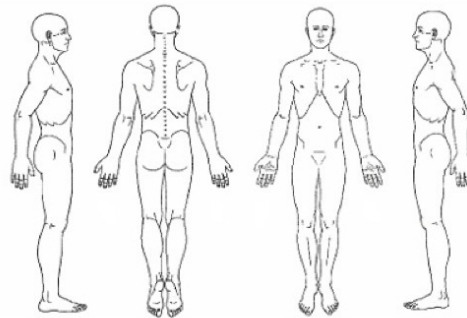
Do you have any PINS or WIRES in your body? _____ If YES, Where? _____

Do you have any other **medical conditions** that I should be aware of? _____

Where are you experiencing discomfort? _____

What is your goal for your session? _____

Please circle any areas of concern:



Important:

I understand that the massage and facial services I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the Therapist so that the products and/or techniques may be adjusted to my level of comfort. I further understand that the massage/facial should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that the Estheticians and Massage Therapists are not qualified to perform, 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 certain spa treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all my questions honestly. I agree to keep the provider updated as to any changes in my medical profile during the session and understand that there shall be no liability on the providers' part should I fail to do so. I also understand that the Massage Therapists reserve the right to refuse to perform treatments on anyone whom they deem to have a condition for which facial, massage or waxing treatments are contraindicated. This information is confidential and will not be passed on to a third party.

Please sign below to confirm that all information is, as of date, accurate.

Signature _____ Date _____

Therapist Signature _____ Date _____