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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_