Massage Profile Card

IZUMI
FOUNTAIN OF YOUTH
WELLNESS CENTER

Name_____

Phone_____

E-mail_____

Address_____

City_____State_____ Zip _____

Date of Birth_____

How did you find us? Referral? Yes_____ Whom?_____

Website? Ad? Angies List? Social Media? Other?_____

Would you like to be on our newsletter list to receive specials? Yes_____ No_____

If yes, what is your email address:_____

(Your email address will be kept strictly confidential and is for our use only. We promise never to spam you.)

MEDICAL:

Are your currently or within the last year under any Doctors care? Yes_____No_____

If yes, please explain_____

_____

Do you have any medical conditions that might interfere or be a contraindication for having this treatment, metal implants, pregnancy, cancer (specifically skin cancer or basal cell treatment, any medical condition I should be aware of? Please explain below:

_____

_____

_____

Have you undergone surgery recently? Yes_____No_____

If yes please explain_____

_____

Pregnancy? Yes___No___If so, how far along? List any complications_____

Do you have any allergies? Please list_____

Have you ever had an allergic reaction to any essential oil or massage product or treatment?

Yes_____No_____ If yes, please

explain:_____

_____

Please list medication, vitamins, street drugs. List all and why_____

_____

Do you smoke? Yes_____No_____if yes how long and how much_____

Do you have any tension or soreness?

Where?_____

Do you bruise easily? Yes___No___

Do you have arthritis? Yes____No____ if so where?_____

_____

Do you have varicose veins? Yes_____No____Where?_____

_____

Do you have Any numbness/soreness Yes_____No____Where? _____

_____

Are you sensitive to touch or pressure in any areas? Yes_____No_____ Where?_____

_____

Do you exercise regularly? Yes_____No_____

How much water do you drink per day? _____

Do you have sinus issues? Yes_____No_____ Explain:_____

Do you wear contacts? Yes_____No_____

Do you get or currently have a headache? Yes_____No_____

Have you had any of the following within the last 6 months? Please check all that apply:

Laser Treatent_____Augmentation/implant_____Botox_____Dermabrasion_____Peel_____

Microdermabrasion_____Resurfacing_____Waxing_____Tanning_____ Fillers_____

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Have you ever had an allergic reaction to any essential oil or massage product or treatment?

Yes_____No_____ If yes, please

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Please take the time to read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, that this treatment may be contraindicated please let me know before treatment, and consult your Physician. A referral from your primary care provider may be required prior to service being provided.

“I understand that this massage treatment is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the service can be adjusted or discontinued. I understand that this service should not be construed as a 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 having. I understand that the aesthetician makes neither claims nor allegations to take the place of medical personal, nor diagnose, prescribe, or treat any medical conditions. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioner’s part should I with hold or forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will not be tolerated and will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment.”

Client Signature_____

Date_____

CANCELATION POLICY:

We require a 24 hour notice for any cancellation. There is a 50% cancellation or no show fee with less than 24 hour notice. If you are 15 minutes or more late for your appointment, your service will be cut short by the amount of time you were late. If you are ill please cancel as soon as possible.