A Matter Of Style Spa Guest Information

All Information Entered Below Is Confidential

Client Information

Date: _____

Guest Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ (_____) _____
Home Cell

E-Mail: _____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____

Occupation: _____

Whom may we thank for referring you? _____

Emergency Contact Information

Name: _____

Relationship: _____

Phone Number: (_____) _____ (_____) _____
Home Cell

Massage History

Have you ever received a professional Massage? _____

If so, what type ☐ Swedish ☐ Deep Tissue ☐ Other _____

What brings you in today? _____

What results would you like to achieve today? _____

Please prioritize the areas of your body that you wish to be massaged.

_____

Please note any areas of your body that you prefer **not to be** massaged.

_____

A Matter Of Style Spa Guest Information

All Information Entered Below Is Confidential

Accident Information

Please fill if applicable

Is condition due to an accident: ☐ Yes ☐ No Date of last accident:_____

Type of accident: ☐ Auto ☐ Home ☐ Work ☐ Other

Do you have any of the following today? ☐ Sunburn ☐ Inflammation ☐ Severe Pain ☐ Headache ☐ Cold/Flu

☐ Irritated skin rash ☐ Poison Ivy ☐ Cuts, Burns, Bruises

Health History

Please check all conditions or symptoms that you currently have or have had in the past.

☐ Anemia	☐ Cancer	☐ Hepatitis	☐ Multiple Sclerosis	☐ Sinus Pressure
☐ Anorexia	☐ Chemical Dependency	☐ Hernia	☐ Osteoporosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Herniated Disk	☐ Pacemaker	☐ Tendonitis
☐ Arthritis	☐ Emphysema	☐ Herpes	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Asthma	☐ Epilepsy	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tuberculosis
☐ Blood Clots	☐ Fibromyalgia	☐ HIV/AIDS	☐ Pneumonia	☐ Tumors/Growths
☐ Breathing Difficulty	☐ Fractures	☐ Jaw Pain/TMJ	☐ Polio	☐ Ulcers
☐ Bursitis	☐ Glaucoma	☐ Lymphedema	☐ Prosthesis	☐ Varicose Veins
☐ Bronchitis	☐ Head Injuries	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whiplash
☐ Bulimia	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other

Medications:_____

Allergies:_____

Exercise: ☐ Less than an hour ☐ 1-2 Hours ☐ 3-4 Hours ☐ 5 or more hours

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Lifestyle: ☐ Smoke Packs/Day _____ ☐ Coffee/Caffeine Cups/Day _____

☐ Alcohol Drinks/Week _____ ☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Trimester: _____ Due Date:_____

Do you have a note from doctor clearing you for a massage? ☐ Yes ☐ No

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

_____

Z:\fZ:\front desk\SGI.docxront

A Matter Of Style Spa Guest Information

All Information Entered Below Is Confidential

Client Medical Condition

When did your symptoms first occur?_____

What treatment(s) have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often does this pain occur?_____Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down