KaLis Day Spa – Massage Treatments

Name: ____ Date: _______________

Address: ____

Cell Phone #: ________________________ Home Phone #:_______________________

Occupation: _____________________________________ D.O.B.: __________________

Email: ____________________________________ Referred By: ____________________

Have you had any P.T, Massage Therapy, or Chiropractic Care this year? ☐ Yes ☐ No

When was your last session? _____________

What is your major concern? ____

Are you exercising regularly? ☐ Yes ☐ No If yes, how often? ________________

What kind of exercise? ____

Do you smoke? ☐ Yes ☐ No If yes, how often? _______________________

Do you have any, or have you had any of the following (please check):

☐ Asthma	☐ Arteriosclerosis	☐ Kidney Problems	☐ Hemophilia
☐ Diabetes	☐ Arthritis	☐ Headaches	☐ Venereal Disease
☐ Varicose Veins	☐ Stomach Ulcers	☐ Hernia	☐ Heart Disease
☐ Epilepsy	☐ Dizziness	☐ Cancer	☐ Phlebitis
☐ Skin Problems	☐ Pins or Plates	☐ Depression	☐ Sinus Problems
☐ Muscular Prob.	☐ High Blood Pres.	☐ Bruising Easy	☐ Hepatitis
☐ Neck, Back etc.	☐ Low Blood Pres.	☐ Fibromyalgia	☐ AIDS

Other problems not listed? ____

Any illnesses or operations? ____

What medication are you currently taking? ______________________________________

Please list any allergies you might have? ______________________________________

Are you currently wearing contact lenses? ☐ Yes ☐ No

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? ______________________

Signature____ Date ___________________

Release Form

I understand that the massage / body work I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and / or strokes may be adjusted to my level of comfort.

I further understand that massage / body work should not be construed as 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.

Because massage / body work is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

Signature____ Date ___________________

Practitioner____ Date ___________________