Tranquility Spa & Massage

Name: _____ Birthdate: _____
Address: _____ City/State: _____ ZIP: _____
Home Phone: _____ Mobile: _____ Work: _____
Email: _____ Physician: _____
Employer/Occupation: _____ Referred by: _____

In Case of Emergency Please Contact:
Name: _____ Phone: _____
Relation to You: _____ Alternate Phone: _____

Please List Any Allergies (if applicable): _____

Please Check All That Apply:

- ☐ Acne
- ☐ AIDS (HIV)
- ☐ Arthritis
- ☐ Asthma
- ☐ Athlete's Foot
- ☐ Carpal Tunnel
- ☐ Cancer/Tumor
- ☐ Chronic Pain
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Glaucoma
- ☐ Headache
- ☐ Heart Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Shingles
- ☐ Impetigo
- ☐ Joint Problems
- ☐ Back Problems
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Neurological Disorders
- ☐ Pregnancy (current term: 1 2 3)
- ☐ Rashes
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Varicose Veins
- ☐ Other:

Are you currently taking any medications? If so, please list: _____
Have you had any major surgeries or injuries? If so, are they related to work or an auto accident? _____
_____
Are you currently seeing a physician, chiropractor, psychologist, or physical therapist for a chronic or ongoing issue? If yes, please explain: _____
Is stress affecting your health and wellness? _____
What are your goals for massage services? _____

All client services and information are strictly confidential.

I understand that the therapist providing services does not practice medicine or chiropractic health care services. I have read the above statements, agree to the terms, and declare the provided information accurate to the best of my knowledge.

Signature: _____ Date: _____
Printed Name: _____

I, _____, parent/guardian of _____
hereby authorize services to be performed on the minor listed above.

Signature: _____ Date: _____
Printed Name: _____