5500 E Cheryl Pkwy Ste. 126
Fitchburg, WI 53711
608-255-0070
KNEADEDRELIEFDAYSPA.COM

Madison's First and Only
Destination Wellness Spa

CONFIDENTIAL CLIENT INFORMATION - MASSAGE

Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number (home)_____ (cell)_____ (work)_____
Email Address:_____
Current Occupation:_____Emergency Contact:_____
Height: _____ Weight_____ Shoe Size:_____ Robe Size: _____
How did you hear about us? _____
From a Friend, please provide his/her name: _____
Confirmation preference (please circle): Home Cell Email Work
Primary Physician & Phone:_____
Have you ever received a professional massage therapy session? Yes No How recently?_____
What type of session did you receive? Swedish Deep Tissue other:_____
What strength of pressure do you prefer? Light Medium Firm

THE FOLLOWING REQUIRED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY, HONESTLY AND TO THE BEST OF YOUR KNOWLEDGE:

Please list any medications and supplements that you are currently taking: _____
_____

Please list ALL allergies or sensitivities, including smells:_____
_____

Do you have any recent skin conditions: Yes or No If yes, please explain: _____
_____

What is your level of stress? Modest Average Severe
Have you ingested any (**please circle**) alcohol, illegal substances, or anti-inflammatory medication in the last 24 hours? Yes or No
Are you currently pregnant? Yes or No How many weeks?_____ Due Date:_____
Do you have any implants? *Pacemaker, Pin in bones, etc.*_____

What is your typical daily intake of:					
	Water?	none	light	moderate	heavy
	Caffeine?	none	light	moderate	heavy
	Salt?	none	light	moderate	heavy
	Sugar?	none	light	moderate	heavy
	Cigarettes/tobacco	none	light	moderate	heavy

Do you exercise and/or stretch on a regular basis? Yes No How often and what type of workout? _____
_____
Please list any recent injuries/surgeries/car accidents? _____
_____
_____
Do you wear (please circle any that apply): contact lenses hearing aids dentures
Do you have any of the following occurring today or in the past week:
cold/flu/fever cuts, bruises, or burns inflammation numbness/tingling skin rash severe pain sunburn
headache: type and frequency:_____

PLEASE CIRCLE ANY HEALTH CONDITIONS BELOW THAT APPLY TO YOU NOW OR IN THE PAST:

Anemia	Depression	Insomnia
Anxiety/Panic Attacks	Diabetes	Jaw Pain/TMJ
Arthritis _____	Digestion Issues	Knee Pain
Arm/elbow/wrist pain	Eczema	Neck/Shoulder Pain
Asthma	Fainting	Numbness/tingling
Back pain	Fibromyalgia	Osteoporosis
Blood clots	Gout	Pacemaker
Bone Disease or disorder	Headaches/Migraines	Paralysis
Broken Bones	Heart Attack	Post-Traumatic Stress Disorder
Bruise easily	Hearing Aids	Rosacea
Bursitis	Hepatitis:_____	Sciatica
Cancer:_____	Heart Problems/disease	Scoliosis
Cardiac Problems	High/Low Blood Pressure	Seizures
Circulatory Problems	Hip/Leg Pain	Stroke
Claustrophobia	HIV/AIDS	Surgery:_____
Chronic Fatigue Syndrome	Implants:_____	Thyroid: _____

Further explanation for any of above conditions or other conditions not listed:_____

_____

Please use the illustration to indicate with an **X** any areas of pain, discomfort, or tightness. Use the space below to further explain your markings:

_____

_____

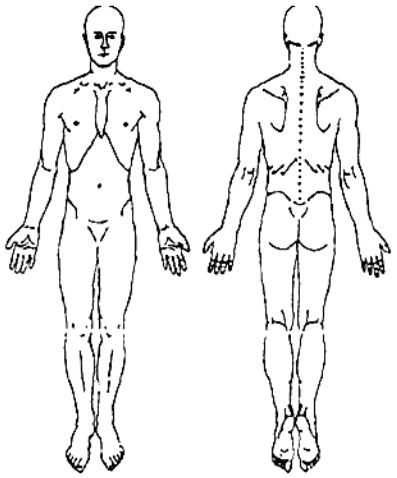
_____

_____

_____

_____

_____



Cancellation Policy: If you must cancel we ask for a 48 hour notice, so that we may offer that appointment to someone on our waiting list. In the event of a cancellation less than 48 hours, there will be a charge for 50% of the treatment cost. In the event of a missed appointment ("no show"), there will be a charge for 100% of the treatment cost. We do understand that emergencies arise and weather conditions may become hazardous. Please call us so that we are aware of your situation.

Kneaded Relief would like to ensure you that your spa visit is exactly what you request. Please be aware that a consultation with your therapist will be a part of your service and is included within the service time. The therapist must be made aware of any existing physical and mental condition; hence I have stated all my known medical conditions. I take it upon myself to keep them updated on my physical and mental health, conditions and concerns, and understand that there shall be no liability on the therapist's or Kneaded Relief's part should I fail to do so. I understand that certain medical issues may contraindicative and may be referred to a medical professional. I understand that communication is an essential part of my treatment and agree to tell my therapist if I am uncomfortable, want less pressure or need more. I also understand that any sexual suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment in full. By signing below I am agreeing to these terms.

Signature:_____ Date:_____