

East Wing Spa

Massage Therapy, Bodywork, Training, Health and Wellness.
305 Maple Avenue West, Suite C, Vienna, Virginia 22180

Confidential Client Information and Consultation Form

Name: First: _____ M.I.: ____ Last : _____ Date: ___/___/___

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: (____) _____ (Cell, Home or Work?)

Secondary Phone # (____) _____ (Cell, Home or Work?)

E-mail Address: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Have you had a professional massage before? ___ YES ___ NO If "Yes", How many? _____

Do you prefer, [] light, [] medium, or [] deep pressure during your massage?

What would you like to get (desired outcome) from this massage/ body treatment session?

List all medications you are currently taking: _____

List any allergies: _____

Place a check mark next to any of the following that apply and provide details as applicable.

[] Frequent headaches

[] Arthritis

[] Varicose Veins

[] Osteoporosis

[] Fibromyalgia/Chronic Fatigue

[] Blood Clots/Phlebitis

[] Cancer (currently or within past 12 months)

[] Any skin rash or condition

[] Diabetes

[] High Blood Pressure

[] Scoliosis

[] Inflammation/swelling

[] Cardiac or Circulatory Problems

[] Chronic Back/Neck Pain

[] Injuries within past 12 months (specify): _____

[] Surgeries wit in past 12 months (specify): _____

[] Pregnant (Due Date: ___/___/___)

[] Any Contagious Disease/Illness: _____

[] Chronic Back/Neck Pain: _____

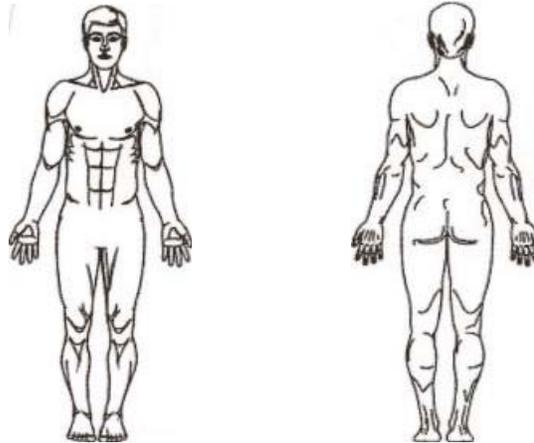
[] Allergies (skin, drug, other): _____

[] Epilepsy

[] Asthma

[] Write **ANY/ALL OTHER** medical condition or health issues: _____

On diagram below please circle the areas of the body that you feel need the most attention in the massage session, and place an "X" over the areas that you wish to have avoided.



Please read the following information and sign where indicated.

I understand that the massage/body treatment I receive is provided for the basic purpose of relaxation, relief of muscular tension and supplementing of general health. There are certain medical conditions in which receiving a massage may be contra-indicated (not recommended). In those cases a referral from a physician may be required prior to services being provided. Massage/body treatment work is not a substitute for medical attention received by a medical specialist. If I experience any pain or discomfort during the session, I will immediately inform the therapist. In addition, if I am uncomfortable for any reason, I may ask that the session be stopped immediately. I may undress completely or down to my level of comfort. However, draping will always be used during massage/body therapy work sessions. No breast massages will be done without consent of the client. Any illicit or sexually suggestive advances made by me (the client) will result in the immediate termination of the session.

To my knowledge, I confirm any and all medical conditions, health concerns and medications I take have been clearly listed above as requested.

I have read and understand all statements above as well as all of the questions and what information is being requested of me:

Client Signature: _____ Date: ___/___/___

Continue below if client is under 18 years of age or not legally allowed to provide consent. Corresponding parent or guardian must be present at all times during treatment session.

Parent or Guardian's Name (PRINT): _____ Relationship: _____

Parent or Guardian's Signature: _____ Date ___/___/___