



# Spa La La

Brows • Skincare • Massage

3425 Bee Caves Rd. Ste B-2 West Lake Hills, TX 78746

## Massage & Bodywork Client Information & Consent Form

**Name** \_\_\_\_\_ **D.O.B** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Mobile** (    ) \_\_\_\_\_

**Email** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**MEDICAL INFORMATION:** *If you have a specific medical condition, massage/bodywork may be contraindicated and could require doctor's approval. Please indicate if you have ever been diagnosed with any of the following conditions listed below:*

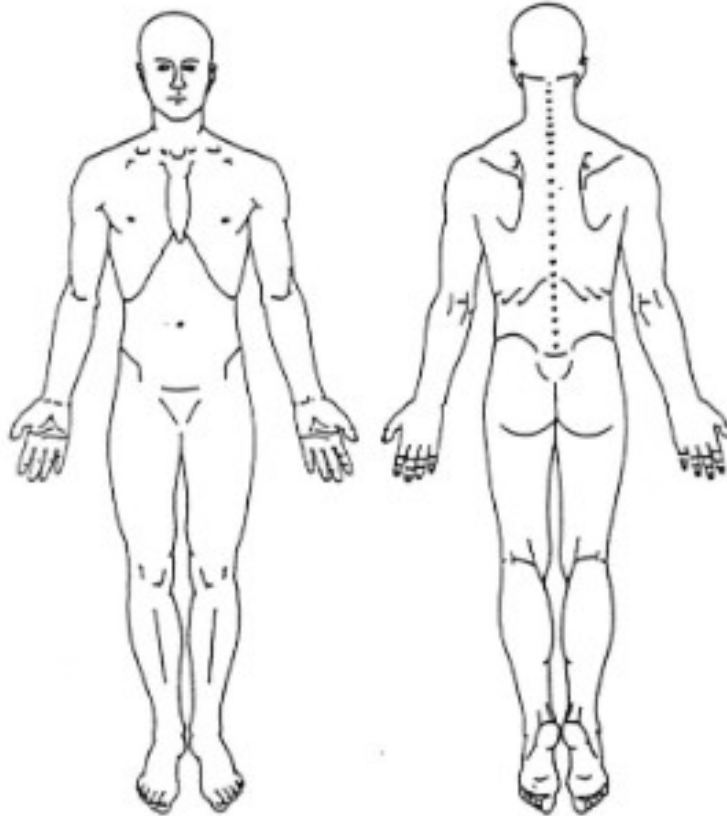
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Allergies</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Hepatitis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Arthritis/Joint Swelling</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>High Blood Pressure</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Asthma</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>High Cholesterol</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Back Pain/Spinal Condition</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Lupus</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Bursitis</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Multiple Sclerosis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Blood Disorder</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Nerve Damage</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Bruise easily</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Osteoporosis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cardiac/Circulatory problems</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Pacemaker</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cancer</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Seborrhea</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Carpal Tunnel Syndrome</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Seizures/Epilepsy</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cystic Fibrosis</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Skin Condition</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Claustrophobia</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Stroke</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Diabetes</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Tendonitis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Fibromyalgia</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>TMJ Syndrome</b>

<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Headaches/Migraines</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Varicose Veins</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Heart Condition/Disease</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Other</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Hemophilia</b>	Please explain: _____	
Overall Stress Level: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High			
Are you currently being treated by a physician? List treatments/medications you are taking to address any health conditions: _____			
List any nutritional supplements you are presently taking: _____			
List any recent injuries, accidents, or surgeries: _____			
Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No    Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how far along are you? _____			
Have you had a professional massage/bodywork session before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how recently? _____ What kind of pressure do you prefer? _____			
<b>Please take a moment to carefully read the following information and sign where indicated.</b>			
<p><i>I, the undersigned, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the 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/bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the course of the given session should be construed as such. Because massage/bodywork and body wraps should not be performed 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 to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that if I make any illicit or sexually suggestive remarks or advances, it will result in immediate termination of the session, and I will be liable for full payment of my scheduled appointment. I relieve <b>Spa La La/Coraly Serrano</b> from any liability resulting from an adverse reaction to any of the services provided.</i></p>			
<b>Client Printed Name</b>	_____	<b>Date</b>	_____
<b>Client Signature</b>	_____	<b>Date</b>	_____
<b>Practitioner Signature</b>	_____	<b>Date</b>	_____

## Body Diagram

**Instructions:**

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

