Inner Essence Spa Confidential Health History

Name:_____ Date Of
Birth:_____

Address:_____

City:_____ State:_____ Zip:_____
Email:_____

Phone(home):_____(cell)_____cell
carrier:_____

Occupation:_____

Therapist Gender Preference **NO YES**_____

How did you hear
about Inner Essence Spa?_____

Have you had a professional massage before?_____

Emergency Contact Info

Name:_____ Relationship:_____

Phone:_____
Email:_____

Are you taking any medications? **NO**
YES_____

Previous
Surgeries:_____

List anything related to your current health
status:_____

_____

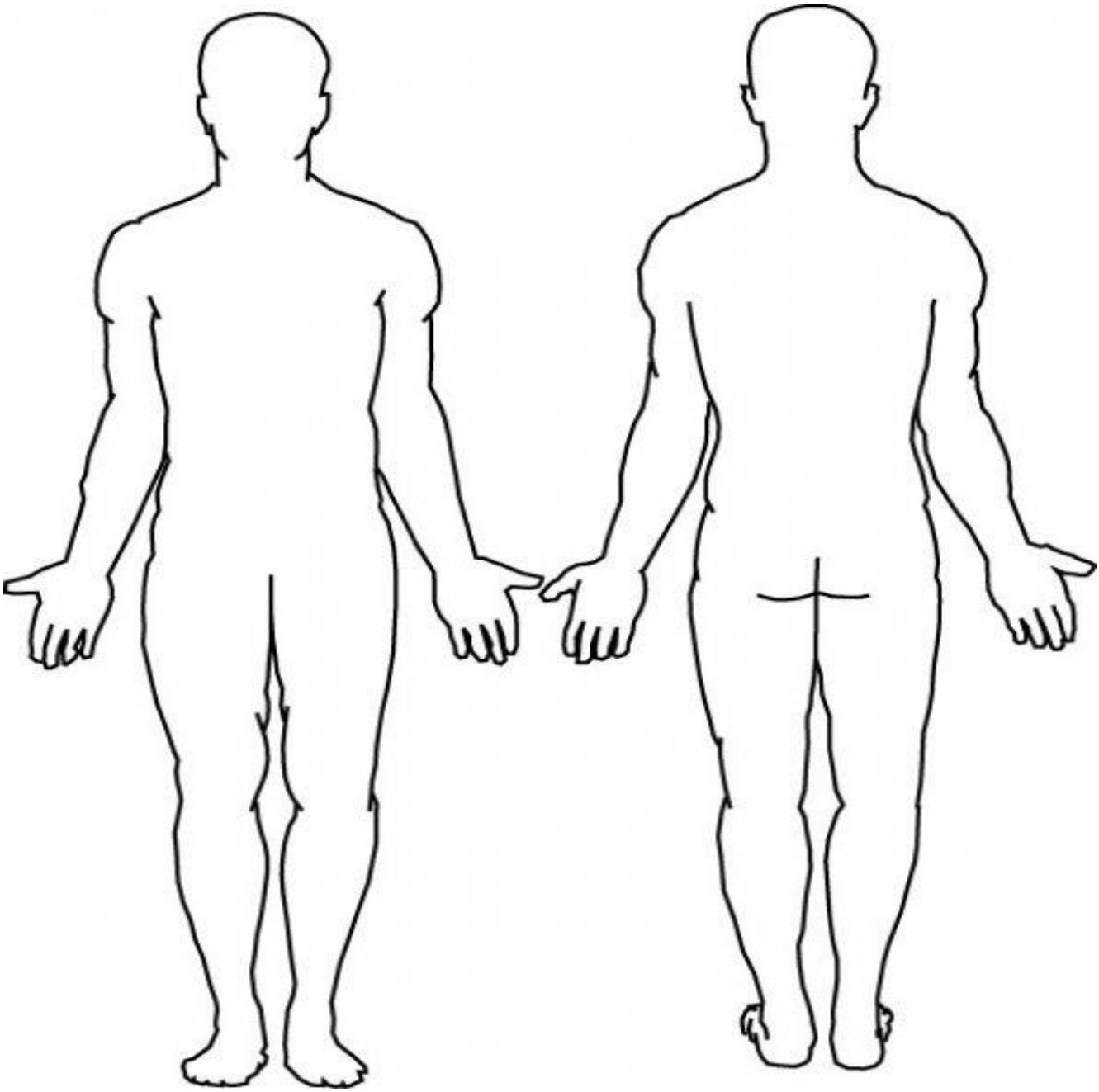
____

Are you affected by or have any of the following? (circle and explain below)

Arthritis Anemia Anxiety Asthma Bursitis Cancer Cardiac/Circulation Problems Blood Clots Depression Epilepsy Headaches High Blood Pressure Hernia Herpes Joint Problems Metal Pins/Implants Muscle Sprain/Strain Osteoporosis Pregnancy Pacemaker RA Skin Disease Simplex Smoker Stress Varicose Veins Vertebral/Disc Problems

_____
_____
_____
_____
_____
_____
_____

Please circle on the diagram below where your pain is and where you hold your tension



Inner Essence Spa LLC is not responsible for the aggravation of conditions, which were present, but not disclosed to the practitioner, at the time of service received and which may be affected by the service. Inner Essence Spa LLC is not responsible for any condition, which may/may not have resulted from experiencing services at our facility. By signing, you are stating that you fully understand the above questions and authorize the treatment(s) you are receiving

Signature_____ **Date**_____

If Under 18, **Parent/Guardian Signature**_____