Alora Health Spa

Patient Information - Massage Therapy (

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Are you currently under the doctor's care? Yes/No If so, why? _____
Do you take any medication? If yes, which ones? _____
_____
Any other medical conditions that we should be aware of? Yes/No If so, please specify: _____
_____
Do you have any allergies towards scented/unscented oils, lotions, or creams? Yes/No If yes, please specify_____
Cancer: What type and when? _____
Surgeries: Which one and when? _____
_____
Please circle if you suffer from any of the following:
Severe Anemia/Asthma/ Allergies/ Diabetes/ Headaches/ Chronic Fatigue/ Aneurysm/ Heart Trouble/ Circulatory/ Respiratory/ High Blood Pressure/ Thrombosis
Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High
If female, are you pregnant? Yes/No If yes, how many weeks? _____

Have you had a professional massage before? Yes/No If so, date of last massage ____/____/_____
Any areas you would like for your therapist to concentrate on? _____
_____
Have you ever had a Lymphatic Massage? Yes/No Last series? _____
Results? _____
Have you ever had a massage with the Cavitation Machine? Yes/No Last series? _____
Results? _____

Do you use any of the following and how often do you use them?
Cigarettes_____ Alcohol_____
Do you exercise? Yes/No How often? _____

In case of an emergency, whom should we call? Phone: _____
Relationship: _____ Name: _____

It is my choice to receive Massage Therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, detoxification of the body, against cellulite, pain, or for increasing circulation and energy flow. I agree to communicate with my massage practitioner anytime I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatments, pharmaceuticals, or perform spinal thrust manipulations. By signing on the line below I am agreeing that the questions above were answered honestly to the best of my knowledge. If a series of sessions was purchased and I decide to cease my treatments, a refund will not be issued to me. I agree to have an open communication with my therapist about any concerns I have before, during, and after my massage. I undersigned, hereby acknowledge that my therapist has not, is not and will not prescribe, (order for use as medicine) for me at any time and I, the undersigned, will not hold them accountable for such.

Signature_____ Date: _____

OFFICE USE ONLY

Notes:_____
_____
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