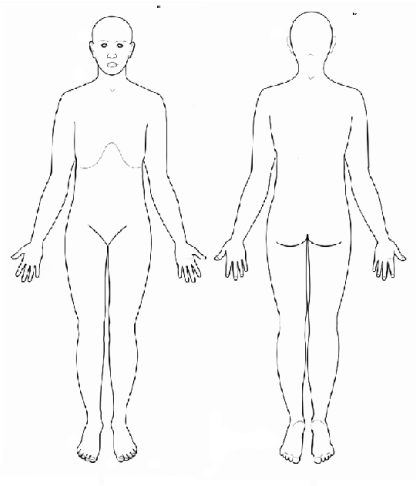
Shimmer Spa
20884 Royalton Road, Suite B
440-783-1473 Strongsville, OH 44149

Guest massage wellness form

Name:_____ Date:_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you ever had an allergic reaction to any of the following? (Please check all that apply and explain)□Citrus essential oils (EO) □Lavender EO □Teatree EO □ Lemongrass EO □ Copaiba EO □Peppermint EO □Avocado Oil □ □Argan Oil □ Coconut Oil Other:_____
2. Have you had a professional massage before?
   Yes No If yes, how often do you receive massage Therapy?_____
3. Do you have any difficulty lying on your front, back, or side?
   Yes No If yes, please explain _____
4. Do you have any allergies to oils, lotions, or ointments?
   Yes No If yes, please explain_____
5. Do you sit for long hours at a workstation, computer, or driving?
   Yes No If yes, please describe_____
6. Do you perform any repetitive movement in your work, sports, or hobby?
   Yes No If yes, please describe_____
7. Do you experience stress in your work, family, or other aspect of your life?
   Yes No If yes, how do you think it has affected your health? (muscle tension) (anxiety) (insomnia) (irritability) ( ) other_____
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   Yes No If yes, please identify_____
9. Do you have any particular goals in mind for this massage session?
   Yes No If yes, please explain_____
10. Circle any specific areas you would like the massage therapist to concentrate on during the session:



11. Are there any areas you WOULD NOT like touched during your session?_____

12. Are you currently under medical supervision?
    Yes No If yes, please explain_____
13. Do you see a chiropractor?
    Yes No If yes, how often?_____
14. 13. Are you currently taking any medication?
    Yes No If yes, please list_____
15. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?____

16. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?
17. Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Guest_____ Date_____

Signature of Massage Therapist_____ Date_____