

SALON 297
Balancing Profile for Body Treatments

Welcome to your Body Treatment at Salon 297 Day Spa. Please take the time to breathe and relax as you fill out this form. The following information will help your therapist better assist your needs.

Name:		Birth Date:	
Address:			
City:	State:	Zip:	
Telephone	Home:	Cell:	
Occupation:			
E-Mail Address:			
Emergency Contact Name:		Phone:	

What prompted your visit today: Please circle all that apply:

Relaxation/Stress General Health & Well Being Gift Certificate
 Accident/Injury/Pain Dr./Specialist Referral: Other

Well-Being Questions: Are you currently affected by any of the following medical conditions?

Arthritis	Skin Conditions	Headaches	Fibromyalgia
Cancer	Carpal Tunnel Syndrome	Fever	Sport Injury
Osteoporosis	High Blood Pressure	Flu/Cold Virus	Recent Surgery
Heart Ailment	Edema	Sore Throat	Allergies
Varicose Veins	Neck/Spine Injury	Phlebitis (Vein Trauma)	Pregnancy
Blood Clots	Vertigo	Tinnitus	Sciatica
Frozen Shoulder	Diabetes	Other _____	

***Is there any chance that you are or could be pregnant?** **Yes** **No**
 Do you have any complications in this pregnancy? Yes No
 Have you experienced any complications in the past? Yes No

Are you wearing: _____ Contacts _____ Hearing Aides _____ Implants

Have you ever had any type of surgery? Yes No

Are you currently under the care of a Health Professional for injuries or on-going Medical Conditions?

Yes No Explain: _____

Are you currently taking any medications? Yes No

Are you experiencing any of the following?

Pain or Soreness Throbbing or Cramping Numbness & Tingling Burning or Shooting Pain Stiffness or Pressure
 Any "hot Spots" or Itching Dizziness Nausea Bruises Swelling Open Cuts/Skin Lesions Warts

Do you have any difficulty lying on your back, front, or turning on your side: Yes No

Female Clients: Are you currently menstruating? Yes No

It is my choice to receive body therapy. I understand that the information given above is strictly confidential and will be used for no other purpose than to assist the therapist in providing a suitable treatment which would take into consideration to my specific requirements. I also understand that failure on my part to disclose information could result in injury and/or illness, and I hereby release Salon 297, Aveda Corporation, and its' parent company from any claims resulting from such. Any information provided to me by the therapist is for general education purposes only and is not intended for any medical or therapeutic purpose.

Client Signature: _____ Date: _____

RETURNING Massage Consent and Release Form

I am signing this form in honesty, to give myself the maximum benefit from my treatment today, and to better protect my health and well-being, and my massage therapist's health and well-being. To my knowledge, none of my health conditions, health care treatments or physical conditions, have changes since the last time I filled out a massage form. I agree, that if any of my medical information has changed, I will inform my massage therapist before our session begins today.

Signature _____ Date _____

Therapist Name: _____ Date: _____

ELEMENTAL NATURE IMBALANCES



Show me where you feel tension or tightness in your body:

Lower Back/ Hips
Legs/ Feet

Torso/Mid-Back
Arms/Hands

Head/Neck/Shoulders
Upper Chest

How is your energy level today?

High/Sporadic

Moderate/Consistent

Low/Sluggish

In general, how is the stress in your life?

High

Moderate

Low

How do you experience stress?

Anxiety/Worry
Nerves

Anger/Irritability
Frustration

Withdrawal
Depression

What was your favorite part of your last facial or massage?

What was your least favorite part of your last facial or massage?

What expectations do you have for your treatment today?

PLEASE CIRCLE WHERE YOU'RE EXPERIENCING PAIN.....

