

SPA ESTIQUE

White Mountains

CLIENT HISTORY

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NAME		DATE	
STREET		CITY	STATE ZIP CODE
PHONE(S)			
BIRTH DATE		REFERRED BY	
PREVIOUS MASSAGE AND FREQUENCY			
REASON FOR SEEKING MASSAGE			
BENEFITS OR RESULTS YOU WOULD LIKE TO ACHIEVE FROM MASSAGE			

CHECK ALL OF THE FOLLOWING CONDITIONS WHICH YOU ARE EXPERIENCING. THIS WILL HELP THE THERAPIST TO TAILOR THE MASSAGE TO MEET YOUR NEEDS.

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|--|-------------------------------------|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cramping | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Ticklishness |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Infectious Condition | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Sciatica | |
- Do you wear contacts? Yes No Do you have problems with your dental work? Yes No

FURTHER EXPLANATION OR OTHER CONDITIONS

RECENT SURGERIES

MEDICATIONS YOU ARE CURRENTLY TAKING

CURRENT INJURY, ILLNESS OR CONDITION REQUIRING SPECIAL ATTENTION OR CARE

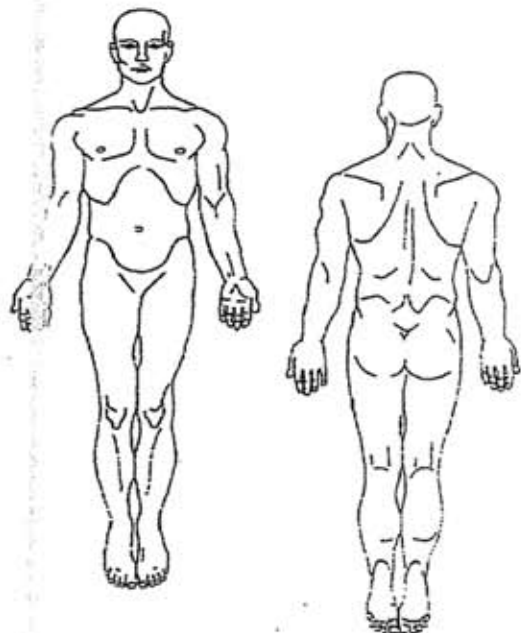
INDICATE WITH AN "X" YOUR PRESENT LEVELS OF:

HEALTH	LOW	HIGH
ENERGY	LOW	HIGH
STRESS	LOW	HIGH

NOTE ANY ANATOMICAL AREAS OF TENSION, PAIN OR CHRONIC DISTRESS ON THE DIAGRAM AT RIGHT OR DESCRIBE:

SIGNATURE

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Thank you for sharing this information. Everything in this questionnaire and all discussion during the massage is strictly confidential.