

Client Information:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: (____) _____ Home: (____) _____ Work: (____) _____

Email: _____

To receive future coupons:

Date of Birth (mm/dd/year): _____ Wedding Anniversary (mm/dd/year): _____

ABOUT THIS PREGNANCY:

The following questions will assist us in being aware of any individual health concerns for both you and your baby. Please notify us of any changes so we can adjust your sessions accordingly. This will insure for a safe, relaxing, and supportive session each and every time.

If a question does not pertain to you, please write NA for your answer rather than leaving it blank.

How many weeks are you in your pregnancy? _____

What is your due date? _____

Is this your first pregnancy? YES NO

How many other pregnancies (not including this one)? _____

Is this your first pregnancy massage? YES NO

What delivery method do you plan on using for this birth? Vaginal C-Section Scheduled Date? _____

Where are you planning on delivering the baby? Hospital Birthing Center Home

Have you discussed receiving a pregnancy massage with your doctor? YES NO

Do you have a doctor's note with you stating you are fit to receive a pregnancy massage? YES NO

Are you experiencing any "high risk" pregnancy difficulties? YES NO

Pregnancy difficulties: mark **H** for History and **P** for Present:

Bed rest		Unusual pain		Heavy discharge		Morning sickness		Fever	
Vomiting		Miscarriage		High blood pressure		Contagious illness		Diarrhea	
Premature birth		Preclampsia		Diabetes		Abdominal pain			

YOUR DOCTOR'S INFORMATION:

Name of Doctor: _____ Facility Name: _____

Phone Number: _____

Practice Guidelines and Boundaries

 **TIME**

- Client will show up on time.
- Client will give 24-hour cancellation notice or the client will be billed for the session.
- A session can be lengthened based on the therapist's schedule.
- If a client shows up late for an appointment, the client will be billed for a full session and treated for the remaining time.
- A one-hour session lasts 60 minutes.
- If an emergency occurs for either the client or the therapist, the session may be rescheduled based on mutual agreement.

 **CONFIDENTIALITY**

- The therapist does not share information about the session with others.
- A written requests is required for any release of client treatment information.

 **TREATMENT**

- The client must have proper hygiene (no open sores, dirty skin, etc.).
- The client determines which pieces of clothing to remove.
- The client disrobes/robes when the therapist is not present in the room.
- The therapist and client will discuss what is most appropriate for each treatment.
- Only the area that is being worked on will be uncovered.
- The client is encouraged to communicate any pain, concerns with pressure, or questions to the therapist.
- An adult must be present in the treatment room for any person under the age of 13 years old during the treatment.
- An adult must accompany any person between the age of 14-18 years old during the treatment.
- I understand that the massage table can safely support 350 pounds of weight and that I am not over 350 pounds.
- **Absolutely NO sexual intonation or behavior is tolerated.**

 **PAYMENT**

- Payment is due at the time when service is rendered.
- Cash, checks, Visa/MasterCard/Discover/AMEX, SpaFinder.
- Gratuity/Tip is greatly appreciated.

Release of Liability

The Sunflower Spa LLC does not perform pregnancy massage until the expecting mother is beyond her first trimester. I understand that it is recommended I speak to my primary healthcare provider about whether or not it is appropriate for me to receive any massage or skincare during my pregnancy. I verify that I am past my first trimester and am experiencing a low-risk pregnancy. I have listed any additional medical concerns pertaining to the health of myself or that of my baby, including any of those not listed on this form.

I understand that a massage therapist or skincare technician does not diagnose illness, disease, or any other physical or mental disorder. As such, he or she does not prescribe medical treatment or pharmaceuticals and does not perform spinal manipulations. The massage therapy or skincare treatment provided is for the purpose of stress reduction, relief from muscular tension or spasms, or for increasing circulation. I further understand that this massage or skincare treatment does not substitute for any medical examination or diagnosis and that it is recommended I see a physician for any ailments I may have.

Because massage therapists and skincare technicians must be made aware of any existing physical conditions, I have stated all known medical conditions and am solely responsible for keeping my therapist and/or technician updated on my physical health. If changes occur, I agree to disclose any additional medical concerns in writing, if requested.

I fully understand that I am receiving a massage or skincare service at my own risk and hereby release Sunflower Spa LLC, its owners, officers, employees, contractors, and all individuals assisting in the conduct of services at the Sunflower Spa LLC from any and all liability. By signing, I testify that the information presented is truthful and accurate.

Signature: _____ Date: _____



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