Sterling Spa

17084 Dallas Parkway
Dallas, Texas 75248
License No. ME1626, MS0064

Client Consultation Document and Informed Consent

Please Fill Out Completely and Print Clearly

Client Number

1. Name	2. Birth Date	3. Email *May we email you with your future appointments' information, discounts and special offers? ❒Yes ❒No	4.Gender ❒ M ❒ F
5. Cell Phone Number	6. Home Phone Number	7. Work Phone Number	
8. Address	City	State	Zip Code
9. Occupation	10. How did you hear about us?	11. Have you had a massage before? ❒ No ❒ Yes	12. Preference in Therapist ❒ Prefer Male ❒ Prefer Female ❒ No Preference
13. Preferred Pressure ❒ Light ❒ Medium ❒ Deep	14. Have you had any **INJURY** or **SURGERY** in the past 12 months? If yes, please explain. ❒ No ❒ Yes		

15. Are you currently being treated by a Doctor, Chiropractor, or any other Physician? If yes, please explain.

16. Please list any health conditions that your Therapist should be aware of:
Current Medications/Vitamins regularly taken: _____

17. TYPE OF MASSAGE REQUESTED:
Interns will perform Swedish Massage (relaxation). Licensed Therapists are familiar with different types of massage; please choose a type of massage from the following list:

- ❒ Swedish Massage (relaxation massage)
- ❒ Deep Tissue
- ❒ Other advanced techniques, please include the type (example: Trigger Point, NMT, Lymphatic Drainage, Prenatal) ……

18. Please check any of the following that apply to you:

❒ Allergies	❒ Epilepsy	❒ Joint Pain	❒ Saline Implants
❒ Arthritis	❒ Exercise Regularly	❒ Kidney Problems	❒ Sciatica
❒ Asthma	❒ Fatigue	❒ Laxatives/Diuretics	❒ Silicone Implants
❒ Athletes Foot	❒ Fibromyalgia	❒ Metal Implants/Pacemaker	❒ Sinus Issues
❒ Cancer	❒ Heart Problems	❒ Migraines	❒ Smokes
❒ Claustrophobia	❒ High Blood Pressure	❒ Muscle Spasms	❒ Spinal Problems
❒ Constipation	❒ HIV	❒ Pregnant	❒ Varicose Veins
❒ Diabetes	❒ Insomnia	❒ Ring Worm	❒ Other _____

Areas of pain/tension: _____

MASSAGE AREA. The massage includes head (scalp), face, neck, shoulders, back, arms, hands, legs, thighs, feet, gluteus (hips/buttocks), upper chest (pectorals, **not breast tissue**) of the body.

Please tell us areas that need to be avoided: _____

Due to policy of Sterling Health Center and Spa, I agree to the massage services indicated on this form and I understand that I will be properly draped at all times during my massage and/or bodywork session; genitalia and women's breast tissue will not be massaged. I understand that neither licensed massage therapists nor massage students (interns) are allowed to diagnose illness, disease, or any physical or mental disorder, nor do they treat injury or illness, prescribe medical treatment, pharmaceuticals, nor perform spinal thrust manipulations. I have stated all medical conditions and if my medical condition and/or status changes in the future, I will fill out a new intake form. If requested, I will provide a medical release from my primary care physician to receive massage and/or techniques requested based on my current medical status prior to receiving massage**. I understand that if I, the Massage Therapist, or Intern becomes uncomfortable for any reason during my session, either party can ask that the session be terminated and the massage session will end.** If I (client) make ANY sexual advance, comment, or action, or if I (client) intentionally expose myself, it will result in IMMEDIATE termination of the massage session with full payment due and I (client) will not be allowed to return for future services provided by Sterling Health Center and Spa. **There will be a $35 fee assessed for no-shows and/or failure to cancel an appointment without a minimal 24 hour notice.** Sterling Health Center and Spa reserves the right to refuse service to anyone. If I (client) am under the age of 17, a Parent or Guardian MUST sign as signature of consent for massage session of said minor and all policies and procedures apply. **If client is under the age of 13, a parent or guardian must also be present during the session. Massage Therapist will use this consultation document prior to the first massage session. If there is any change(s) in any of sections 15-18 above, a new consultation document is to be filled out by the client.**

Client/Parent or Guardian Signature _____ **Date** _____

TO BE COMPLETED BY INITIAL REVIEWING THERAPIST

TYPE OF MASSAGE TECHNIQUE TO BE IMPLEMENTED _____
PARTS OF THE BODY TO BE MASSAGED (Including any Indications and/or Contraindications) _____

Therapist/Intern Signature _____ **Date** _____