



**BEYOND TRANQUILITY SPA**  
 10411 Reserve Drive, San Diego, CA 92127  
 858-829-1776

**Massage & Bodywork Client Information & Consent Form**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Occupation** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_  
**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Email** \_\_\_\_\_  
**Mobile** ( ) - \_\_\_\_\_ **Home** ( ) - \_\_\_\_\_  
**How did you learn about the spa?** \_\_\_\_\_

**MEDICAL INFORMATION**

*If you have a specific medical condition, massage/bodywork may be contraindicated and could require doctor's approval. Please indicate if you have ever been diagnosed with any of the following conditions listed below:*

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Allergies to essential oils</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Hemophilia</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Allergies</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Hepatitis</b>
Please explain: _____		<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>High Blood Pressure</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Arthritis/Joint Swelling</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>High Cholesterol</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Asthma</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>HIV+</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Back pain</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Lupus</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Bursitis</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Multiple Sclerosis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Blood Disorder</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Nerve Damage</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Bruise easily</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Osteoporosis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cardiac/Circulatory problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pacemaker</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cancer</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Seborrhea</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Carpal Tunnel Syndrome</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Seizures/Epilepsy</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cerebral Palsy</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Skin Condition</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Cystic Fibrosis</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Spinal Condition/Injury</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Claustrophobia</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Stroke</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Diabetes</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Tendonitis</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Emotional Stress</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>TMJ Syndrome</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Fibromyalgia</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Varicose Veins</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Headaches/Migraines</b>	<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Other</b>
<input type="checkbox"/> Past <input type="checkbox"/> Current	<b>Heart Condition/Disease</b>	Please explain: _____	

Overall Stress Level:  Low  Medium  High      Do you exercise regularly?  Yes  No

Are you currently being treated by a physician? List treatments/medications you are taking to address any health conditions:  
 \_\_\_\_\_

List any nutritional supplements you are presently taking: \_\_\_\_\_

List any recent injuries, accidents, or surgeries: \_\_\_\_\_

Do you have tension or soreness in a specific area? \_\_\_\_\_

Are you pregnant?  Yes  No      If so, how far along are you? \_\_\_\_\_

Have you experienced a professional massage/bodywork session before?  Yes  No      If yes, how recently? \_\_\_\_\_

What kind of massage/pressure do you prefer? \_\_\_\_\_

**Please take a moment to carefully read the following information and sign where indicated.**

**I, the undersigned, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the course of the given session should be construed as such. Because massage/bodywork and body wraps 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 practitioner updated to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that if I make any illicit or sexually suggestive remarks or advances, it will result in immediate termination of the session, and I will be liable for full payment of my scheduled appointment. I relieve *Beyond Tranquility Spa* from any liability resulting from an adverse reaction to any of the services provided.**

Client Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_