At Last…Salon & Day Spa
185 Park Row
Brunswick, Maine 04011
207-373-0751

Massage Client Information

NAME_____ __HOME #_____ CELL #_____

ADDRESS_____CITY, STATE&ZIP_____

EMAIL ADDRESS_____ D.O.B._____

OCCUPATION_____ STRESS LEVEL (HIGH) (MEDIUM) (LOW)

HAVE YOU EVER RECEIVED A MASSAGE SESSION? (YES) (NO) IF YES, HOW LONG AGO? _____

FREQUENCY OF MASSAGE (1-4/MONTH) (1-4/YEAR) (WHEN I HURT) (SPORADIC/VARIED)

AMOUNT OF PRESSURE PREFERRED (HEAVY_____ MEDIUM_____LIGHT)

ARE YOU PREGNANT? (YES) (NO) IF YES, HOW FAR ALONG? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU HAD ANY OF THE FOLLOWING WITHIN THE LAST 6 - + MONTHS?

__head/neck pains __shoulder pains __back pains (u) (m) (l) __arm/wrist pains __leg pains

__ headaches/migraines __decreased range of motion __allergies to oils/perfumes __broken bones

__seizures __nervous tension __arthritis, bursitis or gout __wears contacts __joint aches

__scoliosis/lordosis/kyphosis __surgery __fibromyalgia __accident __diabetes __HBP

__varicose veins __heart attack/stroke __cancer _____other

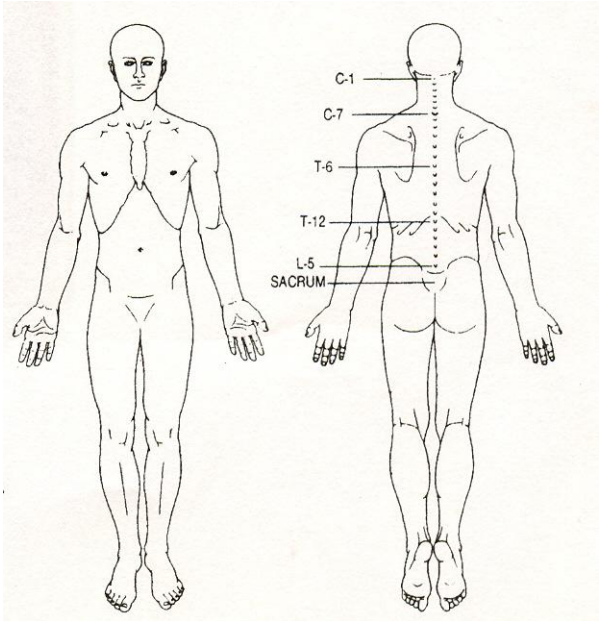
Do you have any of the following today?

__ cold/flu __headache/severe pain __sunburn

__inflammation __open cuts/bruises/burns

__sunburn __poison ivy/oak/rash

Reason (s) for coming today _____



Release Form

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction 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 technique may be adjusted to my comfort level.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any medical or physical ailment I am aware of.

Because Bodywork is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all intake questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile and I understand that there will be no liability on the practitioner's part should I forget to do so.

Should I need to cancel future sessions, I agree to give my practitioner at least 24 hours notice or I will be financially responsible for the session time.

Signed_____ Date_____

Guardian (if client is under 18)_____ Date_____