ADVANCED WELLNESS

aesthetics – massage therapy – foot zone

Welcome! I would like to make your appointment as pleasant and comfortable as possible. Please communicate during the session if you need me to alter my pressure to your comfort level if the music volume or the temperature needs to be adjusted.

Name _____ Date of Birth _____

Phone _____ Email _____

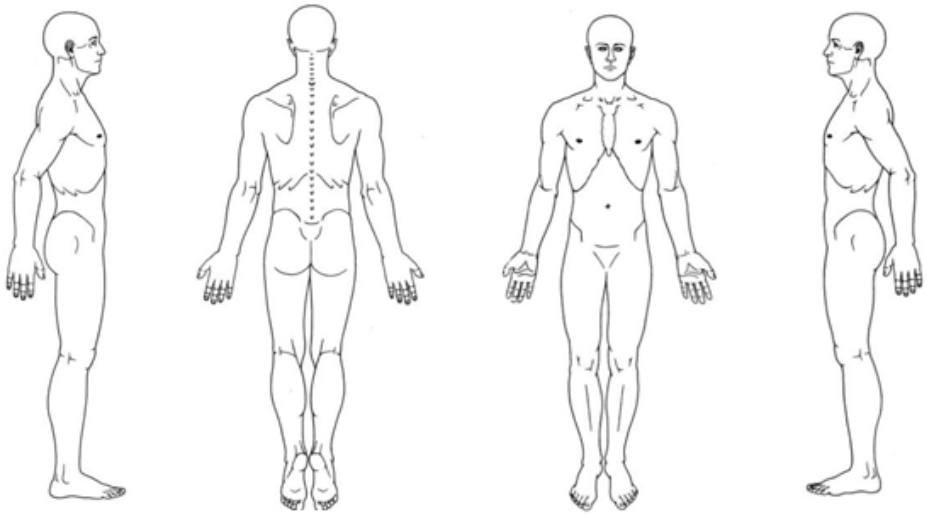
Occupation _____ How did you hear about me? _____

Emergency Contact & Phone _____

Have you ever received a massage before? Y / N If yes, when? _____

Massage pressure preferred: ___ light ___ medium ___ firm ___ deep tissue (extra fee)

Please circle areas to focus on:



Please check any current or recent conditions:

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Shortness of Breath

Cardiovascular

- ☐ Blood Clots
- ☐ Cardiovascular Accident
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lymphedema
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Stroke
- ☐ Thrombosis/Embolism
- ☐ Varicose Veins

Neurological

- ☐ Burning
- ☐ Cerebral Palsy
- ☐ Herniated Disc
- ☐ Multiple Sclerosis
- ☐ Numbness
- ☐ Parkinson's

Skin

- ☐ Bruise Easily
- ☐ Hypersensitive Reaction
- ☐ Melanoma
- ☐ Skin Conditions
- ☐ Skin Irritations

Head & Neck

- ☐ Ear Problems
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Jaw Pain (TMJ)
- ☐ Migraines
- ☐ Sinus Problems
- ☐ Vision Problems

Women

- ☐ Gynecological Conditions
- ☐ Pregnancy (_____)

Soft Tissue / Joint Dysfunction

- ☐ Feet _____R _____L
- ☐ Ankles _____R _____L
- ☐ Knees _____R _____L
- ☐ Hips _____R _____L
- ☐ Lower Back _____R _____L
- ☐ Mid Back _____R _____L
- ☐ Upper back ____R _____L
- ☐ Neck _____R _____L
- ☐ Shoulders _____R _____L
- ☐ Elbows _____R _____L
- ☐ Wrists _____R _____L
- ☐ Hands _____R _____L

Miscellaneous

- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Digestive Conditions
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hemophilia
- ☐ Insomnia
- ☐ Lupus
- ☐ Osteo Arthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ Stress
- ☐ Surgical Pins
- ☐ Other _____
- ☐ _____

Describe your treatment goals:

Cause of Injury or Concern:

Medications and other conditions or critical illnesses your provider should be aware of:

YES NO Do you have heart, lung, or kidney failure?
YES NO Do you have any joint replacements or metal in your body? Where? _____
YES NO Are you sensitive to light?
YES NO Are you taking photosensitive medications where you have been guided to stay out of the sun by a physician? If yes, then consult your doctor prior to use.
YES NO Are you epileptic or prone to seizures?
YES NO Are you currently being treated for cancer?
YES NO Do you have an aversion to essential oils?

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief from muscular tension. I understand that Advanced Wellness is not a substitute for medical examinations, diagnosis, or treatment. I affirm that I have stated all my known medical conditions and answered all questions honestly. I am choosing to use harmonic light energy, exercising my free will. I have solicited use of harmonic light energy and any attending practitioners' services in good faith, I am fully aware and release the practitioner to do a light energy session, wellness consultation and other stress reduction protocols. By signing below, I acknowledge that I have read and understand all parts of this consent for, that, I had the opportunity to ask questions regarding the described procedures, and I hereby affirm, I am not here for medical diagnostic or treatment procedures, and I am here on this and any subsequent visit solely on my own behalf. I also understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session, and I will be liable for the payment of the scheduled appointment.

Signature _____ Date _____