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**Lavender Retreat Wellness Club**

4321 Ridgewood Center Drive, Lake Ridge, VA 22192

Massage

All written records are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client’s legal guardian — unless legally required by local, state or federal subpoena, summons, or other court order.

INFORMATION LAVENDER RETREAT ID NUMBER: \_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Female Male  Single  Married  Widowed  Divorce  Minor

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_ Anniversary Date: \_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case of Emergency, Contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a massage before?  Yes  No

Are you sensitive to fragrances, perfumes or certain types of essential oils? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sensitive skin?  Yes  No If yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses?  Yes  No If yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your pain on a scale of 1 (least pain) to 10 (Most pain): \_\_\_\_\_\_\_\_\_\_\_\_

Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching  Burning

* Tingling  Cramps  Stiffness  Swelling  Other

Does the pain come and go?  Yes  No

Does it interfere with Work  Sleep  Walking  Sitting  Steps  Running

MEDICAL HISTORY: Are you under medical care?  Yes  No Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE INDICATE WHETHER YOU HAVE HAD OR CURRENTLY HAVE:  Abormal Skin Conditions

* Pregnant Allergies/sensitivity Varicose Veins Arthritis Major Accident  Headache Fibromyalgia High/Low Blood PressureHeart/Circulatory Problem Sprain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition due to an accident?  Yes  No

Type of Accident:  Work  Home  Sports Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, specify the reason for your visit:

* Relaxation  Acute Pain  Chronic Pain  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your pain on a scale of 1 (least pain) to 10 (Most pain): \_\_\_\_\_\_\_\_\_\_\_\_

Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching  Burning

* Tingling  Cramps  Stiffness  Swelling  Other

Does the pain come and go?  Yes  No Does it interfere with Work  Sleep

 Daily Routine  Sitting  Standing  Bending  Lying Down  Steps

INFORMED CONSENT (FOR ALL APPOINTMENTS)

**Informed Consent and Massage Policies:**

I understand that the massage I will be receiving at Lavender Retreat is for the purpose of stress reduction and relief from muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe any medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnosis and that it is recommended that I see a physician for any physical ailments that I may have.

I take full responsibility for any of the services that I am receiving today and their circumstances and contraindications. I am responsible to inform the Massage Therapist when any of the information contained in this form changes. I understand that the services offered are not a substitute for medical care, and any information provided by the Massage Therapist is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the Massage Therapist in giving better service and is completely confidential.

Privacy Policy: All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client’s legal guardian – unless legally required by local, state or federal subpoena, summons, or other court order.

I acknowledge that I understand my rights as a client receiving massage therapy services from Lavender Retreat.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Massage Therapist Signature

(Parent or Guardian if under 18 yrs. Old)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Date: