

**Guest Consultation Form For Massage**

**Guest Name:** \_\_\_\_\_

**Sex:** Female \_\_\_ Male \_\_\_

**Email:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

**Birthdate:** \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?** \_\_\_\_\_

**May we add you to our email list? Y/N**

**Age:** Under 20      20-30      30-40      40-50      50-60      60+

**Average of visits to a Massage Therapist yearly:** \_\_\_\_\_

**Why are you seeking Massage Therapy?** \_\_\_\_\_

**CHECK IF APPROPRIATE:**

- |                                       |                               |
|---------------------------------------|-------------------------------|
| Pregnant                              | Undiagnosed pain              |
| Cardio vascular conditions            | Acute rheumatism              |
| Hemophilia                            | Undiagnosed lumps/bumps       |
| Osteoporosis                          | Localized swelling            |
| Arthritis                             | Inflammation                  |
| Any dysfunction of the nervous system | Varicose veins                |
| Bells Palsy                           | High/low blood pressure       |
| Trapped/Pinched nerve                 | Pressure sensitivity          |
| Inflamed nerve                        | Hematoma                      |
| Whiplash                              | Hernia                        |
| Slipped disc                          | Recent Fractures              |
| Cervical Spondylitis                  | Conditions affecting the neck |
| Ticklish                              | Scoliosis                     |
| Other                                 |                               |

**GUEST INFORMATION:**

**Muscular/Skeletal problems:** Back      Aches/Pain      Stiff joints      Headaches

**Circulation:** Heart      Blood pressure      Fluid retention      Tired legs  
Varicose veins      Cellulite      Kidney problems      Colds hands/feet

**Nervous system:** Migraine      Tension      Stress      Depression

**Are you currently on medication?** If yes, which ones? \_\_\_\_\_

**Ability to relax:** Good      Moderate      Poor

**Do you work at a computer?** Yes      No      If yes, how many hours? \_\_\_\_\_

**Do you exercise?** None      Occasional      Irregular      Regular      Types: \_\_\_\_\_

**Do you play sports?** Yes      No      Types: \_\_\_\_\_

**Stress level (1-10, 10 being the highest):** \_\_\_\_\_

**GUEST RELEASE**

I confirm to the best of my knowledge that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or results thereof. I am aware that there are inherent risks associated with massage care services and bodywork. The services I am about to receive could have contraindications which could result in allergic reaction. By signing below, I further agree that I will not hold Orange Skye Day Spa or its affiliates or any of its employees responsible should there be any unfavorable outcome or result.

Please note that all guests are considered late 15 minutes after the appointment time. It may be necessary to reschedule your appointment. We require a 24 hour cancellation notice or service appointment will be charged.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_  
(If under 18)

**Date** \_\_\_\_\_

**Therapist Signature** \_\_\_\_\_

**Date** \_\_\_\_\_