Lavender Retreat Wellness Club

1236 Pennsylvania Ave SE, Washington DC, 20003

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 _____Zip: _____

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 Where is the pain located?

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 Pressure ☐ Heart/Circulatory Problem ☐ Sprain

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
(Parent or Guardian if under 18 yrs. Old)

Massage Therapist Signature

_____ _____

Date:

Date: