



Please complete this form so that your therapist may tailor your session to best serve your needs.
We want your experience to be relaxing, so please turn cell phones off.

Date _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Cell phone _____ Date of birth _____

Goal for today's session:

Please communicate to your therapist anything you think is relevant and check off any of the following conditions or symptoms, which apply to you now or in the past.

- | | | |
|------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Accident or trauma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergy to Nut Oils | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Skin Infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Foot problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Blood Pressure,
High/Low | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Foot fungus or
plantar wart |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypo or
Hyperglycemia | <input type="checkbox"/> Hand problems |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle Sprain /
Strain | <input type="checkbox"/> Pregnant?
_____ months |
| <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Dentures | | |
| <input type="checkbox"/> Allergies _____ | | |
| <input type="checkbox"/> Contagious Conditions _____ | | |
| <input type="checkbox"/> Other Conditions _____ | | |
| <input type="checkbox"/> Recent Surgery _____ | | |

Do you have other concerns your therapist should be aware of? _____

Medications: _____

Disclaimer: I understand that the massage given at Ruby's Spa is for the purpose of relaxation and relief of muscular tension. Ruby's Spa reserves the right to deny treatment due to medical or other reasons. Treatments do not take the place of a physician's care. Any information exchanged during a Massage, Face Treatment or Bodywork session is confidential and is only used to provide you with the best services available. **Use of infrared sauna and steam shower is at your own risk.** Clients under 18 years of age need a parent/guardian signature for any and all services.

Signature _____ Date _____

Parent/Guardian Signature if under 18 years of age _____

Thank you for visiting us at Ruby's Spa. We look forward to your next visit. To schedule a future appointment, please speak with our receptionist.