

BOTANICA

— W E L L N E S S  S A N C T U A R Y —

THIS DOCUMENT IS INTENDED TO COVER ALL MASSAGE TREATMENTS AT BOTANICA INCLUDING PRE-NATAL, LAVA HOT STONE, THAI HERBAL MASSAGE THERAPY, REFLEXOLOGY, LYMPHATIC DRAINAGE, ETC.

Thank you for taking the time to carefully fill out this form. The information you provide will help ensure that the therapist has appropriate knowledge to perform a safe, effective massage.

Date: _____

Name: _____

Email: _____

Phone: _____

Address: _____

Birthday: _____

Whom may we thank for referring you? _____

Office use only: INFO ON FILE

Please continue to the next page

HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add comments to clarify when appropriate.

MUSCULO-SKELETAL

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Tendonitis
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, rib, abdominal pain
- Problems Walking
- Jaw pain/TMJ
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone/Joint Disease
- Other: _____

CIRCULATORY/RESPIRATORY

- Dizziness
- Cold feet/hands
- Cold Sweats
- Swollen Ankles
- Blood Clots
- Stroke
- Heart Condition
- Asthma
- High/Low Blood Pressure
- Lymphedema
- Other: _____

SKIN

- Rashes
- Allergies
- Athlete's Foot
- Other: _____

DIGESTIVE

- Nervous Stomach
- Diverticulitis
- IBS
- Crohn's Disease
- Food Allergies/Sensitivities
- Colitis
- Other: _____

NERVOUS SYSTEM

- Numbness/Tingling
- Twitching
- Fatigue Chronic Pain
- Sleep Disorders
- Ulcers
- Paralysis
- Shingles
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Spinal Cord Injury
- Other: _____

REPRODUCTIVE SYSTEM

- Pregnancy (Current)
- PMS
- Menopause
- Fertility Concerns
- Other: _____

OTHER

- Forgetfulness
- Loss of Appetite
- Confusion
- Depression
- Difficulty Concentrating
- Hearing Impaired
- Visually Impaired
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious Disease: _____
- _____
- Congenital/Acquired Disabilities: _____
- Surgeries: _____
- Other: _____

How did you hear about us?

Friend or Family:

Yelp

Google

ClassPass

SpaFinder

Doctor/Practitioner Referral

Gift certificate

Other: _____

Have you had massage therapy before?

No Yes

What are your goals for this session?

Stress relief/relaxation

Deep muscle work

Rehab/sports/range-of-motion

To address specific areas of concern:

Please indicate if you have any specific preferences:

No talking during session

Avoid certain

Sensitivity to certain smells

areas: _____

Other: _____

Please list any medications you are currently taking:

Please indicate which physical activities you regularly perform and the frequency per week:

Running: _____

Weightlifting: _____

Climbing: _____

Swimming: _____

CrossFit: _____

Sports: _____

Yoga: _____

Other: _____

CLIENT WAIVER

(Please check the boxes below and sign this form at the bottom of the page.)

- I have completed these forms to the best of my knowledge and will inform the massage therapist of any change in my health.
- I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical or emotional disorder, nor perform spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.
- I understand that my massage therapist is a professional practitioner, who is licensed by the State of Colorado through Department of Regulatory Agencies and will uphold their strict ethics and regulations.
- I understand that if the massage therapist starts a session late, she/he will make up the time at the end of the session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me will not be penalized.
- I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I don't provide 24-hour notice to cancel or reschedule.

Thank you! By taking the time to fill out these forms, you have taken the first step in your recovery. We now have valuable information pertaining to your current health that we can utilize to improve your well-being. Please don't hesitate to ask any questions pertaining to this questionnaire or to ask additional questions that you might have regarding our education and background as holistic care providers and massage therapists. We look forward to working with you! By signing below you agree that we have discussed and that you are aware of our practice policies.

Client Signature

Date Signed