Phoenix Salon & Spa
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CONFIDENTIAL CLIENT INFORMATION FORM

Please Print

Name_____Phone_____Birthdate_____
Address_____City_____Zip_____Phone_____
Employer_____Employer's Address_____Phone_____
Occupation_____Chiropractor _____Phone _____
Physician_____Phone_____
Emergency Contact_____Phone_____Relationship _____
e-mail address :_____(E-mail will keep you informed of special promotions.)

Health History:

Are you currently taking any medication?_____If so, what?_____For what condition?_____
Are you Pregnant?_____How many weeks?_____Have you ever had surgery?_____When_____
For what condition?_____Date of last Physical Exam_____
Have you had a recent Injury or Illness?_____What?_____When?_____Hospitalized?_____
What results do you want from your massage?_____
Areas needing special attention in your massage_____

Please check the box in front of any conditions that apply to you.

( ) High Blood Pressure	( ) Phlebitis	( ) Varicose Veins	( ) Blood Clots
( ) Low Blood Pressure	( ) Diabetes	( ) Heart Trouble	( ) Seizures/Epilepsy
( ) Contagious Condition	( ) Cancer	( ) Tumors	( ) Arthritis
( ) Ulcerated Colon	( ) Neck/Spinal Injury	( ) Scoliosis	( ) Back Pain
( ) Headaches	( ) Disc Problems	( ) Stroke	( ) Allergies
( ) Skin Disorders	( ) Athlete's Foot	( ) HIV/Aids	( ) Contacts
( ) Dentures	( ) Muscle Tightness	( ) Sprain/Strain	( ) Numbness
( ) Stress	( ) Fever	( ) Cold/Flu	( ) Sinus Congestion
( ) MRSA	( ) Other _____		

I understand that massage is given for the purpose of stress reduction, relief from muscular tension, spasm, pain, or for increasing circulation. I understand that **Massage Practitioners do not diagnose** illness, disease, or any other physical or mental disorder. They don't prescribe medical treatment, pharmaceuticals, nor perform spinal manipulation. It has been made clear to me that **Massage is not a substitute for medical examination** or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions and will keep my Massage Practitioner updated on my health. I consent to massage therapy. *Initials*_____

Financial Policy:

Payment is due at the time of each visit, unless other specific arrangements are made. I understand and acknowledge that: my health insurance policy is an arrangement between the health plan and myself, I am responsible for all bills incurred during treatment, and that ALL insurance payments are due within 60 days of treatment.

Cancellation Policy: Your appointment is reserved for you. Please give 24 hours notice if you are unable to keep your appointment. If cancelled less than 24 hours in advance will be charged $35.00 for late cancellation. **Reservation is guaranteed with a credit card. Insurance clients will be billed personally for missed appointments.**

No Show Policy: If you do not call and cancel your appointment with 24 hours notice, you may be charged the full amount for your appt. If prepaid with Gift Certificate, Groupon, Monthly Club etc., funds will apply to the missed appointment.

I have read and understand the financial and cancellation policy. *Initials*_____

Privacy Policy

I have been given a copy of the Privacy Policy. I don't have any questions about it. Initials _____
*(**Or:** Initials_____ I have questions and would like the Privacy Officer to contact me.)*

Signature _____ *Date*_____

I Reserve The Right To Refuse Anyone Service