

LA BELLA DONA SKIN CARE

NAME: _____ MALE/FEMALE _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ BIRTHDATE: _____

E-MAIL ADDRESS: _____ HOME PHONE _____

WORK: _____ CELL: _____ CELL PROVIDER _____

HEIGHT: _____ WEIGHT: _____ REFERRED BY: _____

PLEASE LIST ANY INJURIES, SURGERIES OR BROKEN BONES & WHEN:

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU ARE EXPERIENCING:

Emotional Changes	Headaches	Skin Disorders	Hypoglycemia
Phlebitis	P.M.S. Syndrome	Heart Ailment	Diabetes
Pregnancy	Infectious Condition	Sleeplessness	Flu/Cold/Fever
Kidney Ailment	T.M.J. Syndrome	Varicose Veins	Cancer
Allergies	High Blood Pressure	Chronic/Acute Pain	Arthritis
Neck/Spine Injury	Ulcerated Colon	Osteoporosis	Digestive Prob.
Fibromyalgia	Joint Discomfort	HIV positive	Carpel Tunnel
Hepatitis A or B			

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTH PROFESSIONAL? _____

IF YES, HEALTH CARE PROVIDER'S NAME: _____

WHAT TYPES OF EXERCISE DO YOU DO, AND HOW OFTEN? _____

I understand if I experience any pain or discomfort during my session(s), I will immediately inform the therapist so the pressure and/or strokes may be adjusted to my level of comfort. I further understand massage/body work should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. I understand massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, nor treat any physical or mental illness, and nothing said in the course of the session(s) given should be construed as such. Because massage/body work should not be done under certain medical conditions, I affirm I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand there shall be no liability on the practitioner's part should I forget to do so. It is also understood any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "FULL" scheduled appointment.

CLIENT SIGNATURE: _____

PLEASE GIVE 24 HOUR NOTICE IF YOU CANNOT KEEP YOUR APPT.

DATE: _____ **THERAPIST:** _____ **CLIENT COMMENTS:** _____

CMT NOTES: _____

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