TRANQUILITY SPA

Health History Form

Name _____ Mobile Phone _____

Address_____ Mobile Provider _____

City_____ State _____ Zip _____ Occupation _____

Birthdate _____ Email _____

Referred By _____ ☐ Opt-In to receive special offers and promotions via text

The following information will provide your practtioner at Tranquility Spa with information needed to carry out the best possible treament for you. All information contained herein is strictly confidential for the use of the professional practitioner ONLY. (Please Print)

1. Are you currently taking any prescription medication? Yes ❍ No ❍ _____
2. Primary reason for today's visit? _____
3. What are your desired long-term results? _____
4. Recent surgery? Yes ❍ No ❍

If Yes, Please Explain: _____

5. Have you ever had a "professional" massage before? Yes ❍ No ❍
6. When was your last spa treatment? _____
7. Have you ever had cancer? Yes ❍ No ❍
8. Please indicate any known illnesses or allergies. _____
9. Pregnant? Yes No If Yes, _____ Months
10. Do you exercise regularly? What kind/frequency? _____
11. Do you suffer from frequent headaches? Yes ❍ No ❍
12. Do you have high blood pressure? Yes ❍ No ❍
13. Are you Diabetic or Hyperglycemic? Yes ❍ No ❍
14. Do you have sensitive skin? Yes ❍ No ❍
15. Massage Pressure: Soft ❍ Medium ❍ Firm ❍

"I have stated all known conditions and take responsibility to inform my Therapist of any new information regarding my physical condition. I understand that there shall be no liability on the Therapists' part should I forget or neglect to do so."

Signature: _____ Date: _____