CLIENT INFORMATION & PROFILE FORM

Instructions *for first visit:*
Print this form. Fill out all applicable information and call your nearest centre to set an appointment. ***Please bring this form with you.***

Name _____ Birth Date _____

Address _____ Telephone # _____

City _____ ST ____ Zip _____ Business # _____

Occupation _____ Email:_____

May your service provider call you by your first name? YES NO

Is this your first Hamam or Spa Service ever? YES NO

What are your goals for this treatment? _____

_____

Have you ever had a negative reaction to any skin care product? (If yes, please explain)

_____

_____

Do you have any open wounds? YES NO Please Describe:_____

Are you pregnant? YES NO Number of Weeks:_____

Are you wearing contact lenses? YES NO Do you have any allergies? YES NO

Please Describe any allergies:_____

Have you received Massage Therapy or Bodywork before? _____ What Kinds? _____

How often? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

___ High Blood Pressure
___ Contact Lens
___ Low Back Pain
___ Allergy to Nut Oils
___ Osteoporosis
___ Diabetes
___ Pregnant
___ Blood Clots
___ Low Blood Pressure
___ Varicose Veins
___ Bursitis
___ Skin Infections
___ Hypo or Hyperglycaemia
___ Contagious Conditions
___ Muscle Sprain / Strain
___ Heart Attack / Stroke
___ Arthritis
___ Headaches
___ Other Conditions

Please list and explain other conditions/symptoms you are or have experienced: _____

_____

Have you had any serious or chronic illness, operations, or traumatic accidents? _____

If yes, please explain: _____

_____

Are you currently, or have you at any time within the last 12 months been under the care of a physician? If so, for what condition?_____

_____

Do I have your permission to contact your Doctor? _____

Doctor Name: _____ Telephone# _____

Do you exercise? _____ How many times per week? _____ For how long? _____

What percentages of the foods you eat would you say are:

Grains _____ Fruits _____ Meats _____ Fish _____ Dairy _____

Vegetables _____ Desserts/Sugar ___ Junk Foods ___

How many ounces of water do you drink per day? _____

Do you drink caffeinated beverages? _____ If so, how many bottles/cups per day of the following?

Soda Pop_____ Coffee_____ Black Teas_____

Do you smoke cigarettes? _____ How many per day? _____

Do you consume alcohol? _____ How many drinks per: Day _____Week _____

Client Declaration:

I have completed this health form to the best of my knowledge. I understand that Massage Therapy (Spa Therapies / Hamam Bath Services) and Bodywork services are a therapeutic health aid and are non-sexual. They do not take the place of a physician's care when indicated. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

I, , understand that spa and hamam bath services provided by H2O-The Indian Hamam are intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

I am aware that the technician does not diagnose illness or disease, and does not prescribe medications. I am also aware that spinal manipulations are not part of massage therapy.

I will inform the technician of all my known physical conditions, medical conditions and medications, and I will keep the technician updated on any changes. I understand that H2O-The Indian Hamam is not responsible for any injuries or illness that may be caused because of withheld information.

If I am not able to make a scheduled appointment, I agree to cancel the appointment at least 4 hours in advance by phone, unless I have an emergency. In this case, I will call as soon as possible to reschedule my appointment.

If I miss a scheduled appointment without giving four (4) hours notice, I agree to pay half of the appointment charge applicable.

Guest Signature: _____ Date:_____