crimson salon & spa
an AVEDA concept salon

Massage Therapy Waiver

Welcome to your Aveda Massage. Please take the time to breathe and relax as you fill out this form with the required information. We look forward to working with you.

Full Name

Street Address

City | State | Zip code

( ) Home Phone Number | ( ) Work Phone Number | ( ) Cell Phone Number

Email Address | Date of Birth

Occupation | Hours Per Week

What prompted you to come in today? Circle all that apply.

Relaxation | Stress | Personal Growth

Injury/Pain | Other _____

Well-Being Questions

Are you currently affected by any of the following conditions? Circle all that apply.

Arthritis	Carpal Tunnel Syndrome	Fever
Heart Ailment	High Blood Pressure	Flu Cold Virus
Varicose Veins	Edema	Sore Throat
Allergies	Neck/Spine Injury	Sports Injury
Phlebitis	Warts or Other Skin Condition	Diabetes
Recent Surgery	Pregnancy	

Other (Please Explain): _____

If you circled Pregnancy, please complete the next two questions

1a. Do you have any complications in this pregnancy? YES _____ NO _____
If yes, please explain _____

1b. Have you experienced any complications in the past? YES _____ NO _____
If yes, please explain _____

2. Have you ever had any surgery? YES _____ NO _____
If yes, please explain _____

3. Are you currently under the care of a Health Professional for injuries or on going medical treatment? YES _____ NO _____
   If yes, please explain _____

4. Do you have any medical conditions, health problems, or other physical conditions? YES _____ NO _____
   If yes, please explain _____

5. Are you currently taking any medications? YES _____ NO _____
   If yes, please list _____

6. Dr. Name _____ Telephone _____

Lifestyle Questions

1. Do you smoke? YES _____ NO _____
2. Do you exercise regularly? YES _____ NO _____
3. Do you wear contact lenses? YES _____ NO _____
4. Do you wear dentures? YES _____ NO _____
5. Do you wear a hearing aid? YES _____ NO _____
6. Have you ever had a professional massage? YES _____ NO _____
   If yes, when? _____ By whom? _____
7. Do you have any difficulty lying on your back, front, or turning on your side?
   YES _____ NO _____ If yes, please explain _____
8. Female Clients: Are you currently menstruating? YES _____ NO _____

10. How did you hear about our salon/spa services?
    Website App Social Media Advertisements Word of Mouth

    Referral _____ Referral by whom _____

We reserve the right to refrain from providing a massage service until written permission is given by your medical professional.

Important Note: It is my choice to receive massage therapy. I understand that the information given above is strictly confidential and will be used for no other purpose than to assist the massage therapist in providing a suitable massage which would take in consideration all my specific requirements. I also understand that failure in my part to accurate information could result in injury and/or illness and I hereby release from Corporation and its parent company from any claims resulting from such. Any information provide to me by the massage therapist is for general educational purposes only and is not intended for any medical or therapeutic purpose.

Client Signature _____ Date ____/____/____

Therapist Name _____

Therapist Signature _____ Date ____/____/____