Xpert Kneads Consultation

Todays Date: _____

Your answers to the following questions are considered confidential. This consultation is necessary to ensure the treatments you are interested in are not contraindicated because of any health, or other concerns. Please fill out the front and back as complete and accurate as possible. **Xpert Kneads reserves the right to refuse any service to any guest for any reason.**

Last Name: _____First Name: _____

Date of Birth: _____ ___Male ___Female

How did you hear about Xpert Kneads? _____

Are you a local Resident? ___Yes ___No ___First Visit ___Return Visit

What best describes how often you receive massage treatments?

- ❑ This is my first massage
- ❑ I've received a massage within the last year
- ❑ About once a month
- ❑ 2 to 4 or more times a month

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____

Are you undergoing any medical or other type of therapeutic treatments? ___Yes ___No
If yes please explain:

List any medications you are taking: _____

If necessary, do you have your doctor's permission to receive massage and body work treatments? ___Yes ___No

If applicable, do I have permission to consult with your doctor? ___Yes ___No

Doctor's Name: _____Doctor's Phone: _____

Health History

Indicate your health history by marking the box in front of any of the following conditions that apply to you and clarifying if necessary.

Muscular-Skeletal	Skin	Reproductive System	Circulatory/Respiratory
❑ Headaches ❑ Joint Stiffness ❑ Broken/Fractured Bones ❑ Strains/Sprains ❑ TMJ ❑ Tendonitis ❑ Bursitis ❑ Arthritis ❑ Osteoporosis ❑ Scoliosis ❑ Other: _____	❑ Rashes ❑ Allergies ❑ Athlete's Foot ❑ Nail Fungus ❑ Warts/Moles ❑ Acne ❑ Herpes/Shingles ❑ Cosmetic Surgery ❑ Other: _____	❑ Pregnant/Trimester: ___1st ___2nd ___3rd ❑ PMS ❑ Menopause ❑ Hysterectomy ❑ Other: _____	❑ Dizziness ❑ Shortness of Breath ❑ Swollen Ankles ❑ Blood Clots ❑ Stroke ❑ Heart Condition ❑ Asthma ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Lymphedema ❑ Other: _____
Digestive	**Nervous System**	**Other**	**Clarifications**
❑ Nervous Stomach ❑ Constipation ❑ Gas/Bloating ❑ Diarrhea ❑ Irritable Bowel Syndrome ❑ Adaptive Aids ❑ Other: _____	❑ Numbness/Tingling ❑ Paralysis ❑ Cerebral Palsy ❑ Epilepsy ❑ Multiple Sclerosis ❑ Muscular Dystrophy ❑ Parkinson's Disease ❑ Other: _____	❑ Smoking ❑ Depression ❑ Hearing Impaired ❑ Visually Impaired ❑ Diabetes ❑ Fibromyalgia ❑ Cancer ❑ Surgeries ❑ Infectious Disease ❑ Other: _____	

I, the undersigned (Guest), acknowledge the information disclosed on the front and back of this document is accurate to the best of my knowledge. I understand massages, treatments, and use of amenities will be limited to guests and physical areas without contraindication for massages, treatments, or use of amenities.

Guest Signature: _____ Date: _____

(If under 18 a legal parent or guardian must consent and sign above.)