THE SPA AT CYPRESS BEND RESORT

CLIENT INFORMATION/MASSAGE CHECK-IN FORM

CYPRESS BEND RESORT
A WYNDHAM HOTEL

PERSONAL INFORMATION

NAME _____ **BIRTHDAY (M/D/YY)** _____

PHONE NUMBER (DAY) _____ **(EVENING)** _____

ADDRESS _____ **ROOM NUMBER** _____

CITY _____ **STATE** _____ **ZIP** _____

OCCUPATION _____ **EMPLOYER** _____

EMAIL _____ **PRIMARY PHYSICIAN** _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____ **PHONE** _____

HOW DID YOU HEAR ABOUT US? _____

MEDICAL INFORMATION

Are you taking any medication? ___ No ___ Yes

If yes, please list name and use: _____

_____

Are you currently pregnant? ___ No ___ Yes

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ___ No ___ Yes

If yes, please explain: _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ___ No ___ Yes

If yes, please list: _____

Please indicate any of the following that apply to you.

___ Cancer
___ Fibromyalgia
___ Headaches/Migraines
___ Stroke
___ Arthritis
___ Heart Attack
___ Diabetes
___ Kidney Dysfunction
___ Joint Replacement(s)
___ Blood Clots
___ High/low Blood Pressure
___ Numbness
___ Neuropathy
___ Sprains or Strains

Explain any conditions you have marked above: _____

_____

_____

MASSAGE INFORMATION

Have you had a professional massage before? ___ No ___ Yes

What type of massage are you seeking?

___ Relaxation ___ Therapeutic/Deep Tissue

Other: _____

What pressure fo you prefer?

___ Light ___ Medium ___ Deep

Do you have any allergies or sensitivities? ___ No ___ Yes

Please explain: _____

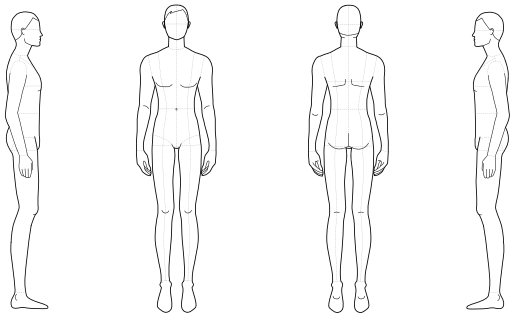
Are there any areas (feet, face, abdomen, ect.) you do not want massaged? ___ No ___ Yes

Please explain: _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort:



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____