Confidential Health Information

First Name	MI	Last Name		Email
Address	City	State	Zip	Occupation

Home Phone	Cell/Work Phone	Emergency Contact Phone	Date of Birth

How did you hear about us?

☐ Website ☐ Yellow Pages ☐ Facebook ☐ I'm a Valley Member ☐ Referral/Other_____

Medical History (check all that apply)

- ☐ Pregnant or lactating (term _____)
- ☐ Hypo/hyper thyroid
- ☐ Heart disease / pacemaker
- ☐ Diabetes, Epilepsy, Hemophilia
- ☐ High/low blood pressure
- ☐ Cancer, HIV, Immune Disorder, Herpes
- ☐ Open wounds / lesions / infections
- ☐ Carpal Tunnel Syndrome
- ☐ Skin conditions
- ☐ Contact lenses
- ☐ Sciatica
- ☐ Tendonitis
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Plantar Faciitis
- ☐ Headache/Migraines
- ☐ Kidney disease
- ☐ Infectious condition
- ☐ Spinal injuries
- ☐ Bulging disc
- ☐ Asthma / lung conditions
- ☐ Varicose veins
- ☐ Arthritis: Rheumatoid/Osteo
- ☐ Motor vehicle accident
- ☐ Whiplash
- ☐ Surgery
- ☐ Blood clots
- ☐ Depression
- ☐ Chronic pain
- ☐ Chronic illness
- ☐ Athlete's Foot
- ☐ Sleeping disorder

Please describe and include year for any checked boxes: _____

_____

Please answer the following:

Yes	No	
☐	☐	Have you ever had a professional massage?
☐	☐	Do you exercise regularly? If so, how often? _____
☐	☐	Are you taking any medication (Aspirin, Ibuprofen, herbal remedies, vitamins, etc.)? If yes, please specify: _____
☐	☐	Do you have any known allergies or sensitivities? If so, indicate which substances affect you (specifically iodine or seaweed) _____
☐	☐	Do you have any other medical conditions that the practitioner should be aware of before you receive your massage (fever, infection, acute inflammation/swelling, common cold)? _____
☐	☐	Do you have any special needs or areas that require special attention? If yes, please specify: _____

Turn Over ➡

Cupping Client Consent

(Applicable to clients receiving Cupping Therapy)

With the treatment you are receiving today there is important information to consider including possible risks that may occur. By initialing below, you are agreeing that you understand this information and risks.

_____ Information has been explained to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations as explained. It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.

_____ It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory systems. I further understand that the discolorations may take up to 2 weeks to dissipate.

_____ I understand that the first time I experience Cupping, my body's immune system may react to this release, producing flu-like effects including but not limited to nausea, headache, and aches. I understand that water and rest may help to dilute the intensity of the release. I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, a minimum of 4 hours after shaving, after sunburn or when I'm hungry or thirsty. I understand that hot showers, baths, saunas, hot tubs and aggressive exercise should be avoided for at least 4 - 6 hours after treatment. I understand that exposure to such extremes may produce undesirable effects and I should avoid such situations.

Policy Disclosures

Please initial after each policy to state that you read and understand the policy

_____ I understand that giving 24 hours notice or more for cancellations or rescheduling will not result in any charge for that appointment.

_____ I understand that any missed/cancelled appointments without 24 hours notice will result in charge of the full amount of the service and will be charged to the credit card I have provided on file (non-members), gift card, or my Valley membership (members only).

_____ I understand that any returned check will result in a charge of $25.00. I will then only be able to pay with cash or credit card for future appointments.

I understand that if I have any concerns, I will address these with my massage practitioner. I give permission to my massage practitioner to perform the procedures we have discussed, and I agree to hold harmless the Valley Athletic Club LLC, The VSpa, its employees and agents from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my massage practitioner will take every precaution to minimize or eliminate negative reactions as much as possible. I understand that massage practitioners do not diagnose illness, disease, or other medical, physical, or emotional disorders or prescribe treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that I am responsible for consulting a doctor for any physical ailment I might have. In the event I may have additional questions or concerns regarding my treatment, I will consult the massage practitioner immediately. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I agree to hold harmless the Valley Athletic Club LLC, The VSpa, its employees and agents for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I also affirm that I am at least 18 years of age, or have parental consent to receive my massage today (if under 18, parent or guardian signature must be present). Since spa services have been reserved especially for me, I will notify The V Spa 24 hours in advance to change/ cancel appointments without penalty.

Signature	Date