Client Record

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it. All information disclosed will be kept for session purposes only and in strict confidentiality.

Date_____Therapist_____

Name_____ Birth Date_____

Address_____ Apt/Suite_____

City_____State_____Zip_____

Cell _____ Home_____

Occupation_____E-Mail_____

Emergency Contact_____Phone_____

Can we share your review on our website? ☐

How did you hear about the Floating Lotus Spa? ☐ Internet ☐ Advertisement ☐ Friend_____ ☐ Other_____

Medical Health History Information

Please list medications._____

_____

Have you had any major surgeries and when? _____

_____

Do you have a pacemaker or are you pregnant? (Please provide details) _____

_____

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort. ****

By signing below, I state that all of the information on this form is accurate. I understand that the services I receive are provided for the basic purpose of relaxation, stress reduction and/or relief of muscular tension. I agree to keep the spa updated as to any changes to my medical profile, and I understand there will be no liability on the spa or the therapist's part if I fail to do so. I release the Floating Lotus Spa and therapists of any and all liability.

Please indicate if signing for a child. Yes ☐ No ☐

<u>The Floating Lotus Spa has a 24 hour cancellation policy. Any appointment that is not cancelled within 24 hours, or is missed, will have a 50% fee of all services booked for that day.</u>

Signature_____ Date_____