

Client Record: BioMat Therapy

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 _____
Name _____ Birth Date _____
Address _____ Apt/Suite _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Occupation _____ E-Mail _____
Emergency Contact _____ Phone _____

Would you like to be added to our email list?

How did you hear about the Floating Lotus Spa? Internet Advertisement Friend Other

Please mark the correct box for any conditions that you currently have or have had in the past:

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Bone/Joint Disease | <input type="checkbox"/> Using Pain Patch |
| <input type="checkbox"/> Bone/Joint Injury | <input type="checkbox"/> Using Nicotine Patch |
| <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw Pain/TMJ |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Lower Back/Hip Pain |
| <input type="checkbox"/> Heat Sensitive MS | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness/Swelling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Painful Feet/Swelling |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pregnant? # wks _____ |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Renal or Kidney failure | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Botox Injections |

Please indicate the primary reason(s) for your visit today:

- Relaxation
- Pampering
- Stress Relief
- Therapeutic
- Pain Management
- Other: _____

PLEASE COMPLETE REVERSE SIDE >

Medical Health History Information

Please list medications. _____

Have you had any major surgeries and when? _____

Do you have an external 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 relief of muscular tension. I further understand that these services should not be a substitute for medical examination, diagnosis, or treatment.

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____

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 25% fee of all services booked for that day.

Signature _____ Date _____