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:

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