tocarspa
THE ESSENCE OF TOUCH

PLEASE READ AND SIGN

Welcome to Tocar Spa.

We're delighted you have chosen our massage therapy services. Tocar Spa only employs professional massage therapists. If requested, the clinic administrator will provide a proof of your therapist's license/permit. Additionally, if you have any questions, comments or complaints about your massage therapist, please bring it to the attention of the management immediately.

Male and female genitalia and women's breasts will not be exposed or massaged at any time. Modest draping will be used during the session. If during the session you feel uncomfortable in any way, simply ask your therapist to end the session. It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the level of pressure or heat. You understand and voluntarily accept any risks associated with your massage, as well as any risk associated with the use of any use of Tocar Spa's facilities.

You hereby release Tocar Spa, including its employees, practitioners, agents, and insurers, from any and all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting from your use of Tocar's services and/or facilities and from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation, or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session for any reason.

The undersigned acknowledges that he / she has read this agreement.

Signature _____

Date _____

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CLIENT INTAKE FORM

NAME _____ ☐ MALE ☐ FEMALE DATE: _____

STREET ADDRESS _____ APT. # _____ CITY _____

STATE _____ ZIP _____ HOME _____ CELL _____

EMAIL ADDRESS _____ DATE OF BIRTH _____

EMERGENCY CONTACT NAME _____ PHONE _____

☐ Please check here if you DO NOT wish to receive e-mails regarding what's new, special offers or latest news.

1. Please check any of the conditions below that are currently applicable.

- ☐ allergies* (e.g., lanolin, latex, nuts, seaweed)
- ☐ epilepsy
- ☐ osteoporosis
- ☐ arthritis
- ☐ fever
- ☐ recent scar tissue
- ☐ asthma
- ☐ fibromyalgia
- ☐ rosacea / sensitive skin
- ☐ back/neck problem
- ☐ fungal disease
- ☐ skin disorder
- ☐ bruises/broken capillaries
- ☐ heart condition/ pacemaker stroke
- ☐ cancer* heat sensitivity sunburn
- ☐ cold sores/herpes
- ☐ high/low blood pressure
- ☐ thrombosis
- ☐ contagious condition/disease*
- ☐ metal pins/plates
- ☐ thyroid problem
- ☐ claustrophobia
- ☐ multiple sclerosis
- ☐ varicose veins
- ☐ diabetes
- ☐ open wounds
- ☐ other*

* Please provide additional information

2. Are you pregnant? ☐ Yes ☐ No

3. Are you currently experiencing any skin conditions? ☐ Yes ☐ No

4. Are you currently or have you within the past six months been prescribed medication? ☐ Yes ☐ No If yes, please list.

5. Have you experienced any of the following in the past three months: pain, numbness, swelling, tingling, fatigue, etc.?

☐ Yes ☐ No If yes, please explain.

6. List daily activities that are inhibited by your current condition(s)

7. Are you comfortable with having therapeutic massage on the following areas: (check all that apply)

Gluteal Region ☐ Yes ☐ No Abdomen ☐ Yes ☐ No Pectoral Muscles ☐ Yes ☐ No Feet/Face/Head ☐ Yes ☐ No

Desired Pressure ☐ Light ☐ Firm ☐ Deep