

## 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 \_\_\_\_\_

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.

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