

Wellness by Gudbrandsgard

Client Record Card

Personal Information

Name: _____

Telefon number: _____

E-mail: _____

Treatment Today (please tick)

- Classic Massage – 60 mins
- Aroma Massage – 60 mins
- Classic Massage – 30 mins
- Aroma Massage – 30 mins
- Face and Body – 90 mins

Medical Information

Do you have any of the following medical conditions? Please tick YES if applicable and provide further details below. Discuss with your therapist before the treatment.

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Metal Plates or Pins |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Joint/Arthritic Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Recent Operations |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Medication (please specify) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other medical conditions (please specify) |

Additional Information: _____



Allergies and Experience

Are you allergic to any type of oils? Yes No

Have you had a massage before? Yes No

Areas to Avoid During Massage

Please tick any areas with aches, pains, or sensitivity:

- Upper Back
- Lower Back
- Neck/Shoulder Area
- Front of Legs
- Back of Legs
- Arms
- Feet
- Facial Area
- Scalp Area

Additional Information: _____

Confidentiality Statement

All information provided is strictly private and confidential. It will not be shared with third parties or stored in our system without your consent.

This information ensures a safe, comfortable, and effective treatment.

Date: _____

Client Signature: _____

