

### Massage Intake Form - Confidential Information

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

Client Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Unit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Home or Cell (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Under 21 \_\_\_\_\_ 21-30 \_\_\_\_\_ 31-40 \_\_\_\_\_ 41-50 \_\_\_\_\_ 51-60 \_\_\_\_\_ 60+

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive the Spa’s special offers and coupons by email? YES or NO (Please circle one)

Have you ever experienced massage therapy before? YES or NO (Please circle one)

What type of massage have you experienced? (Swedish, Deep Tissue, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? YES or NO (Please circle one)

If yes, please list name and reason for medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently seeing a healthcare professional? YES or NO (Please circle one)

If yes, please list name and reason for treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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### Please review this list and check those conditions that have affected your health recently or in the past:

\_\_\_\_\_ Arthritis \_\_\_\_\_ Auto-Immune Condition

\_\_\_\_\_ Back Problems \_\_\_\_\_ Blood Clots

\_\_\_\_\_ Broken/Dislocated Bones \_\_\_\_\_ Bruise Easily

\_\_\_\_\_ Cancer \_\_\_\_\_ Chemical Dependency (Alcohol, drugs)

### Do you have any of these conditions today? \*\*\* Please understand full disclosure of any communicable health condition (i.e., cold, flu, conjunctivitis) is necessary to keep you and our staff healthy. If any of these conditions are present, we will kindly ask you to reschedule your appointment.

\_\_\_\_\_ Cold or Flu

\_\_\_\_\_ Insomnia

\_\_\_\_\_ Muscle Strain/Sprain

\_\_\_\_\_ Pregnancy

\_\_\_\_\_ Scoliosis

\_\_\_\_\_ Seizures

\_\_\_\_\_ Skin Conditions

\_\_\_\_\_ Stroke

\_\_\_\_\_ TMJ Disorder

\_\_\_\_\_ Open Cuts

\_\_\_\_\_ Skin Rash

\_\_\_\_\_ Severe Pain

\_\_\_\_\_ Injuries or Bruises

\_\_\_\_\_ Whiplash

\_\_\_\_\_ Hepatitis

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Chronic Pain

\_\_\_\_\_ Constipation/Diarrhea

\_\_\_\_\_ Depression/ Psychological Conditions

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Diverticulitis

\_\_\_\_\_ Headaches

\_\_\_\_\_ Heart Conditions

### Are you allergic to any of the following?

\_\_\_\_\_ Environmental Allergens

\_\_\_\_\_ Food Allergens

\_\_\_\_\_ Medications

\_\_\_\_\_ Skin Care Products

If yes, please give details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have metal implants, a pacemaker, or body piercings? YES or NO (Please circle one)

Please indicate below by checking, if any, the areas in which you are feeling discomfort



Please check areas of the body that you give permission to massage

\_\_\_\_\_ Abdomen \_\_\_\_\_ Buttocks \_\_\_\_\_ Legs \_\_\_\_\_ Arms \_\_\_\_\_ Face \_\_\_\_\_ Neck \_\_\_\_\_ Back \_\_\_\_\_ Head \_\_\_\_\_ Upper Chest

What are your goals & expectations for this therapy session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*A need to move or change position, sighs, yawns, changes in breathing, stomach gurgle, emotional release, energy shift, falling asleep and memories are all normal responses that can occur during massage. Trust your body to express what it needs to.

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and can reduce muscular tension; it is not a substitute for medical examination, diagnosis or treatment.

2. This is a therapeutic massage and any sexual remarks or advances on my part will terminate the session immediately and I will be liable for payment of the scheduled treatment.

3. Massage should not be done under certain medical condition, and I affirm that I have answered all questions pertaining to medical conditions truthfully.

4. Due to the physiological aspects of massage therapy, consuming alcohol prior to a massage or body treatment is strictly prohibited.

**If you or a member of your household has been diagnosed with COVID-19, we kindly ask that you reschedule your appointment AT LEAST ten days beyond your diagnosis and have had AT LEAST three days without symptoms. If you have been exposed to COVID-19, we kindly ask you to receive a negative test before receiving a service.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_