
# Massage Intake Form

Please be assured that all information given will be strictly confidential.

First and last name_____ Date_____

Address_____ City_____ State_____

Zip code_____ Birth date_____ Mobile Phone #_____

Home Phone #_____ E-mail_____

Emergency Contact_____ Relationship_____

Phone #_____

When was your last massage?_____

How frequently do you receive massage therapy?_____

What type of pressure do you like? Light_____ Medium_____ Firm_____

In what area(s) of your body do you generally hold stress?

_____

What is your stress level? Low_____ Moderate_____ High_____ Extremely HIgh_____

What are your goals and expectations for this massage?

_____

Please describe the type and frequency of exercise you engage in?

_____

**(Please continue on the back page)**

What hobbies and activities do you engage in?

_____

Have you had any recent serious injuries, broken bones, or surgeries? Yes___ No____
If yes, please describe _____

Please list any health condition(s) that are being treated by medication:

_____

Do you have allergic reaction to any oils, lotions or other substances applied to your skin?
Yes____ No____
If yes, please explain _____

Check all that apply to your current health:

| | | |
|---|---|---|
| ___ Headaches | ___ Numbness/Tingling | ___Vericose Veins |
| ___ Fatigue | ___ Blood Clots | ___ High/ low blood pressure |
| ___ Sleep difficulties | ___ Scoliosis | ___ Muscle of joint pain |
| ___ Depression | ___ Tendonitis | ___ Cancer/ Tumors |
| ___ Jaw pain | ___ Arthritis | ___ Diabetes |
| ___ Vision problems | ___ Lymphatic condition | ___ Infectious disease |
| ___ Sinus problems | ___ Osteoporosis | ___ HIV/ Aids |
| ___ Pregnancy | ___ Open cuts, rashes or burns (where?_____) | |

**Client Agreement**

-I understand that massage is not a substitute for medical evaluation or treatment.
-I freely give my permission for the therapy received.
-I understand this treatment will be therapeutic in nature and under no circumstances will there be any sexual behavior.
-I take full responsibility for this treatment and for the healing that occurs, and understand that there could be some discomfort and soreness in the healing process.
-I am responsible for informing my therapist of any relevant medical conditions or concerns and will keep my therapist updated if there are any changes at future appointments.
-I am responsible for paying for any appointment I miss or cancel with less than 24 hours notice.
-I have read, understand, and agree to all the terms above. By signing below I agree to hold harmless Annie RItter and Illumine Skin and Wholeness Spa for this treatment and any future services I receive with this business.

_____ _____

Client Signature Date