# Massage Therapy Client Intake Form

The Body Sculpt SPA by S & S
DREAM BODY LOADING...

## General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Physician's Name | Physician's Phone #:

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

## Medical History

Please check all that apply:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Digestive Conditions
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Frequent Colds
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attacks
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Jaw Pain (TMJ)
- ☐ Low Blood Pressure
- ☐ Lyme Disease
- ☐ Multiple Sclerosis
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Psychiatric Disorder
- ☐ Rashes
- ☐ Ringing In Ears
- ☐ Sciatica
- ☐ Seizures
- ☐ Sensory Loss/Change
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Smoker
- ☐ Stroke
- ☐ Tendonitis
- ☐ Vertigo/Dizziness
- ☐ Vision Loss
- ☐ Vision Problems
- ☐ Other: _____

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under medical care? Yes ☐ No ☐

Are you or could you be pregnant? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Do you see a chiropractor? Yes ☐ No ☐

If yes, how often:

Do you suffer from chronic pain? Yes ☐ No ☐

If yes, please explain:

Do you sit for long periods of time? Yes ☐ No ☐

If yes, please explain:

Have you had any major accidents or surgeries? Yes ☐ No ☐

If yes, please explain:

How would you describe your stress level (1 being lowest, 10 being highest):

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache

☐ Inflammation ☐ Insomnia ☐ Muscle Cramps ☐ Stress

## Additional Information

Have you had a professional massage before? Yes ☐ No ☐

If yes, when:

Do you have difficulty laying on your front, back, or side? Yes ☐ No ☐

If yes, when:

Are you sensitive to touch or pressure on any areas of your body? Yes ☐ No ☐

If yes, when:

Are there areas that you do not want massaged? Yes ☐ No ☐

If yes, when:

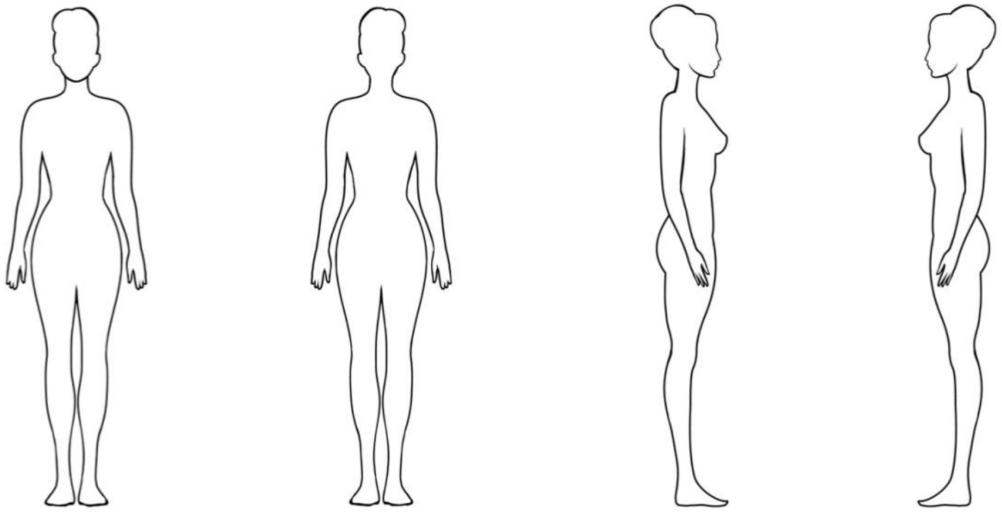
**Are you sensitive to fragrances or perfumes?**

| | | |
|---|---|---|
| Do you have sensitive skin? | Yes ☐ | No ☐ |
| Do you wear contact lenses? | Yes ☐ | No ☐ |
| Do you wear dentures? | Yes ☐ | No ☐ |
| Do you wear a hearing aid? | Yes ☐ | No ☐ |
| Do you exercise regularly? | Yes ☐ | No ☐ |

What pressure level would you like?

☐ Light ☐ Medium ☐ Firm

Please circle the areas you would like your therapist to focus on:



Front Back Right Left

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the massage therapist of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the massage therapist of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my massage therapist and the spa for any injury or damages incurred due to any misrepresentation of my health.

Name Printed _____ Signature _____ Date _____

**Are you sensitive to fragrances or perfumes?**

| | | |
|---|---|---|
| Do you have sensitive skin? | Yes ☐ | No ☐ |
| Do you wear contact lenses? | Yes ☐ | No ☐ |
| Do you wear dentures? | Yes ☐ | No ☐ |
| Do you wear a hearing aid? | Yes ☐ | No ☐ |
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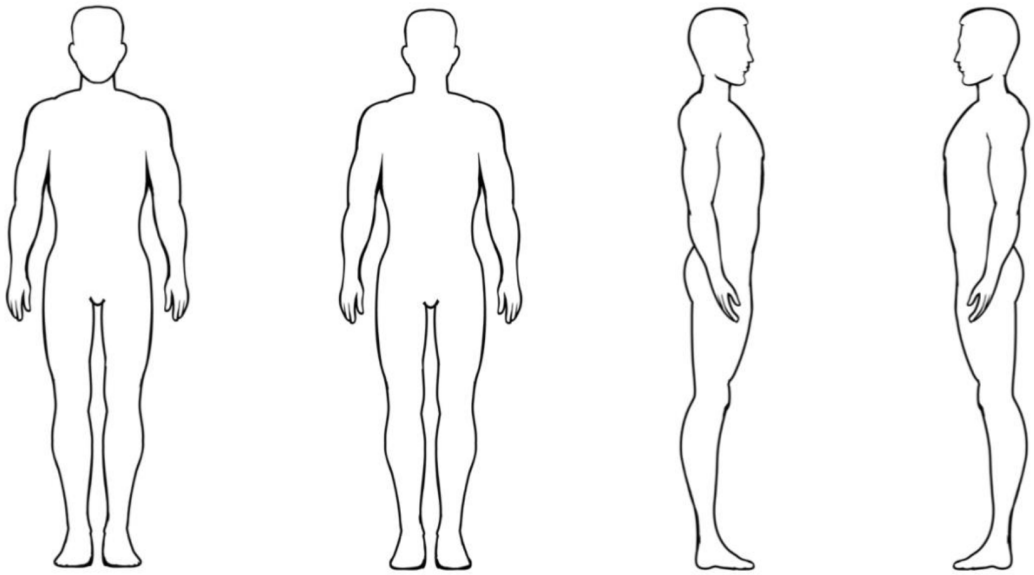

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Name Printed _____ Signature _____ Date _____

# Massage Therapy Informed Consent Form

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Please take a moment to read and initial the following information:

_____ I understand the benefits and risks of massage and give my consent for massage.
_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
_____ I understand that there is no implied or stated guarantee of the success of the effectiveness of individual techniques or series of appointments.
_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
_____ I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
_____ I affirm that I have notified my therapist of all known medical conditions and injuries.
_____ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
_____ I understand that massage is entirely therapeutic and non-sexual in nature.
_____ I understand that draping will be used for my privacy and that genitalia and women's breasts will not be exposed or touch at any time.
_____ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

**By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.**

| Name Printed | Signature | Date |
|---|---|---|
| Massage Therapist Name | Signature | Date |

**Consent to Treatment of Minor:**

By my signature below, I hereby authorize the massage therapist to administer massage or bodywork therapy techniques to my child or dependent as they deem necessary.

| Name Printed | Signature | Date |
|---|---|---|