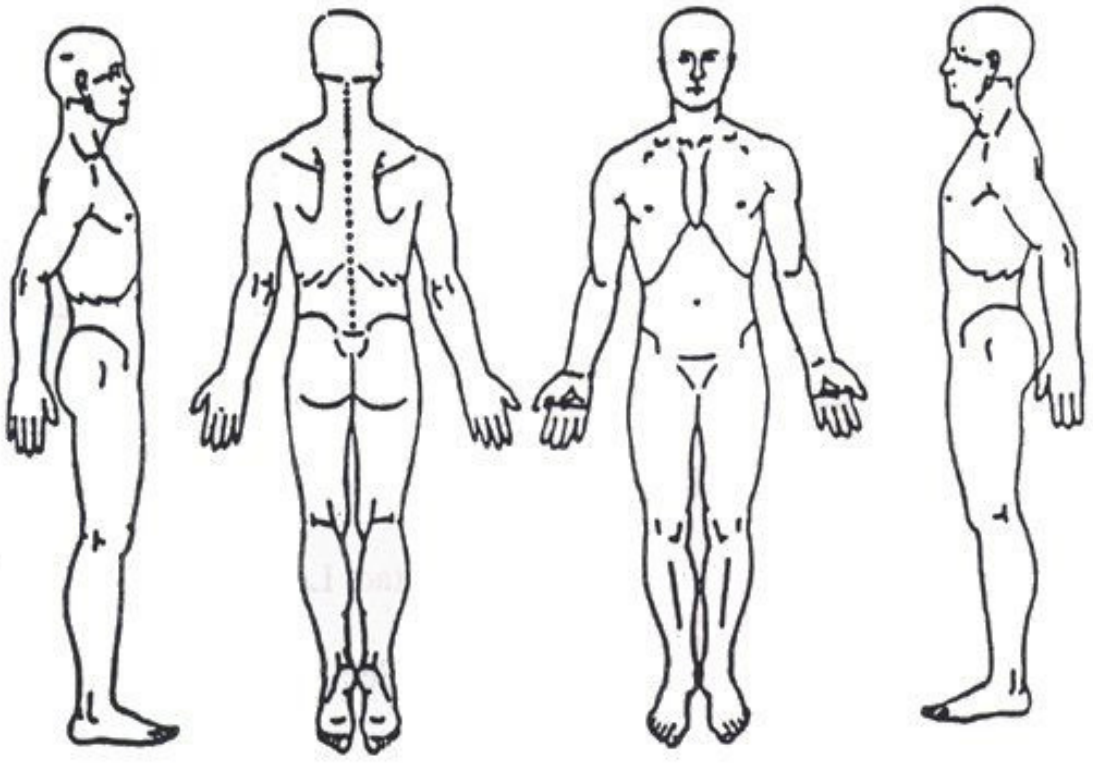
Massage Therapy Intake

First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Phone (Cell) _____ Email _____

☐ I understand that the booking system used by Akcent Day Spa, LLC uses text messaging and email to confirm appointments and cancellations. By checking this box, I provide my consent to receive periodic text messages and/or emails with appointment reminders and promotions and note that consent to these terms is in no way a condition of purchase.

How did you hear about us? _____
Referral Client Name _____
Reason for Visit _____
Is this your first professional massage? **YES** **NO**
If **NO**, how often do you get a massage? _____
Please state any recent injuries, surgeries, accident and medical treatments. _____
_____

Circle any specific areas you would like the massage therapist to concentrate on during the session.



(OVER)

Please **CIRCLE** any conditions you currently have. **CHECK** any conditions you have had in the past.

☐ Neck/Spine Injury	☐ High Blood Pressure	☐ Headaches	☐ Liver Ailment	☐ Back Pain
☐ Low Blood Pressure	☐ Kidney Ailment	☐ Sciatica/Leg Pain	☐ Skin Disorders	☐ Heart Ailment
☐ Carpal Tunnel	☐ Infectious Disease	☐ Fibromyalgia	☐ TMJ Syndrome	☐ Diabetes
☐ Cancer	☐ Sport Injuries	☐ Arthritis	☐ PMS Syndrome	☐ Cold/Flu/Fever
☐ Grief Process	☐ Varicose Veins	☐ Pregnancy (__) months		

Are you currently under the care of a physician? **YES** **NO**
If **YES**, please list reason(s) _____
Please list any medications taken now or at regular intervals:_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: _____ Date _____

TO BE COMPLETED BY THERAPIST:

Name: _____ Services Rendered: _____

Additional Notes: