

Z-va Day Spa – Minor Massage Client Intake Form

Personal Information: *(Please print clearly)*

Name _____ Date _____

Street Address _____

City: _____ State: _____ Zip: _____ Phone #: _____ Cell #: _____ Carrier: _____

Email: _____ Would you like promotional Emails: Y / N

Birthdate: _____ Age: _____ Anniversary Date: _____ Occupation _____

Emergency Contact: _____ Phone: _____ Who do I thank for your referral? _____

Medical History:

In order for me to plan a safe and effective massage session; I need some general information about your medical history. Please answer the questions to the best of your knowledge.

1. Are you currently under medical supervision? Yes No If yes, please explain: _____

Health Practitioner's name: _____

May I have permission to contact your Health Practitioner? Yes No Phone no. _____

2. Do you see a chiropractor? Yes No If yes, how often? _____

3. Are you currently taking any medicine? Yes No If yes, please list _____

4. Please check any condition listed below that applies to you:

<input type="checkbox"/> Recent injury / fracture	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Recent illness	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> High or low blood pressure
<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Decreased sensation
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Other circulation problems: _____
<input type="checkbox"/> Joint problems	<input type="checkbox"/> Wear contact lenses	<input type="checkbox"/> Contagious skin conditions
<input type="checkbox"/> Chronic illness/health problems	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Cancer or undiagnosed growths
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Back/neck problems	<input type="checkbox"/> Heart condition
<input type="checkbox"/> Open sores or wounds	<input type="checkbox"/> Current fever	<input type="checkbox"/> Headaches / migraines
<input type="checkbox"/> Allergies / sensitivities	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tennis elbow
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> Artificial joint	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pregnancy If yes, due date _____
<input type="checkbox"/> Sprains / Strains	<input type="checkbox"/> TMJ disorders	<input type="checkbox"/> Other _____

Please explain any condition you have marked above: _____

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I will use the following information to help me plan safe and effective massage sessions.

Please answer the questions to the best of your knowledge.

5. Have you had a professional massage before? Yes No If yes, how recently and how often? _____
6. Do you have any difficulty lying on your stomach, back, or side? Yes No
If yes, please explain _____
7. Do you have any allergies to oils, lotions, ointments, or fragrances? Yes No
If yes, please explain _____
8. Are you wearing: () contact lenses () dentures () a hearing aid? No
9. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please explain _____
10. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please explain _____
11. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
() muscle tension () anxiety () insomnia () irritability other _____
12. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
Yes No If yes, please identify _____
13. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

Circle any specific areas where you currently have or have had pain within the past year:

Headaches	Back	Chest	Abdomen	Hip	Leg
Shoulder	Neck	Arm	Pelvis	Groin	Buttock

14. Is there anything else about your health history that you think would be useful for me to know in order to plan a safe and effective massage for you? _____

It is my choice to receive massage therapy. I, _____ (***print name***) realize that the treatment is being given for the wellbeing of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Z-va Day Spa Cancellation Policy

*If you call or email us 24 hours prior to your appointment, you **will not** be charged a rescheduling fee;*

*If you are unable to give us 24 hours advance notice we reserve the right to charge you a minimum of a **\$25 fee** for your appointment time;*

*If you are unable to give us a minimum of 4 hours advance notice we reserve the right to charge you the **full price of your appointment**;*

This amount will be charged to your account at the time of your scheduled appointment.

*If you are a **"No-Show"** meaning you **have not called or emailed** us that you will not be here for your scheduled appointment*

"You will be charged full price for the session"

Signature of client _____ Date _____

Parental/Guardian if under the age of 18 _____ Date _____

Signature of Massage Therapist _____ Date _____