Z-va Day Spa 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: _____ Occupation _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who do I thank for your referral? _____

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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 _____

Z-va Day Spa Massage Intake Form

Name _____ Date _____

Birthdate: _____ Age: _____ Occupation _____

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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. Have you had a professional massage before? Yes No If yes, how recently and how often? _____

2. 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

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

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

Please explain any condition you have marked above: _____
_____
_____

4. 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._____

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

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

Continue on next page

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.

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. 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.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____