Refreshing Springs Day Spa – Massage Therapy Intake Form

Name: _____ Date: _____ Male/ Female

Date of Birth: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Cell #: _____-_____-_____

Client D.O.B. _____/_____/_____ Occupation : _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name/Relationship: _____

Cell #: _____-_____-_____ Email Address:_____@_____

How did you hear about us? _____

What is your major complaint today?

_____

_____

Are you pregnant? **Yes** ☐ **No** ☐ If yes, when are you due? _____

Have you had surgery before? **Yes** ☐ **No** ☐ If yes, please describe: _____

Have you suffered an acute injury lately? **Yes** ☐ **No** ☐ If yes, please describe:

_____

Do you have *(circle all that apply)*:

varicose veins
blood clots
arthritis
heart problems
spinal problems
high blood pressure

Do you have/suffer from: claustrophobia? **Yes** ☐ **No** ☐
allergies to latex? **Yes** ☐ **No** ☐
food allergies? **Yes** ☐ **No** ☐ _____
other allergies? **Yes** ☐ **No** ☐_____

Are you currently on any medications? **Yes** ☐ **No** ☐ If yes, please list all medications:

_____

Are you presently in any pain? **Yes** ☐ **No** ☐ If yes, please list where:

_____

Please list any rashes or skin eruptions or bruises:

_____

Please mark (X) all conditions that apply.

( )Auto Immune Condition
( )Bursitis
( )Cancer: Type _____
( )Cold hands/Cold Feet
( )Depression
( )Diabetes
( )Diarrhea/ Constipation
( )Dizziness
( )Edema/Swelling
( )Fatigue
( )Headaches
( )Hepatitis (A,B,C)
( )Hearing problems
( )Herniated Disc
( )HIV
( )Insomnia
( )Numbness
( )Osteoporosis
( )Vision Problems
( )Sciatica
( )Sinus Problems
( )Sprains
( )Strains
( )PMS
( )Stomach disorder
( ) Whiplash injury

( )Other, Please list:_____

What type of pressure do you like on a scale *(circle one of the following)*:

1 - 4	5 - 7	8 - 10
(Swedish)	(Combination)	(Deep)

Is there anything you'd like your therapist to know before starting the massage?

_____

_____

Because a Massage Therapist must be aware of any existing physical conditions that I may have, I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health.

I understand and agree that: (1) the massage therapy that I am given is for the purpose of stress reduction, relief for muscular tension or spasm and/ or for improving circulation: (2) that a massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations: (3) I am responsible for consulting a qualified physician for any physical ailments that I may have. I am fully aware of the risks involved and hazards connected with skin care treatments, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me because of being engaged in such an activity, whether caused by the negligence or otherwise.

Signature: _____ Date: _____