CLIENT INTAKE FORM – MASSAGE THERAPY

First Name: ________________________________ Last Name: _____________________________________

Address: ____

City: ______________________________________ State: __________________ Zip: ______________

Check the primary phone number to reach you regarding your appointments.

☐ Home: ___________________ ☐ Cell: ____________________ ☐ Business: ____________________

Do we have your permission to send newsletters and occasional promotions to your email address? ☐ NO ☐ YES

Email address: ____

Birth Date: ___________________ Age: ____________ Male / Female

Occupation: ____ Mostly: ☐ Sitting ☐ Standing ☐ Driving

Activities: ____

Referred By: ☐ Health Care Provider: _________________________ ☐ Advertisement
☐ Center MedSpa Employee: _____________________ ☐ Gift Certificate
☐ Family or Friend: _____________________________ ☐ Other: __________________

Emergency Contact: Name: _________________________________ Phone: ___________________
Relationship: ____________________________

For your safety & well-being, please answer a few health related questions. This information remains confidential.

Check the following conditions or symptoms that apply to you both past and present:

☐ Allergies	☐ Bursitis	☐ High / Low Blood Pressure	☐ Skin Disorders / Irritations
☐ Arthritis	☐ Cancer	☐ Infectious Disease	☐ Sprains / Strains
☐ Asthma	☐ Claustrophobia	☐ Kidney / Liver Disease	☐ Stroke
☐ Autoimmune Disorder	☐ Epilepsy / Seizures	☐ Migraines	☐ Varicose Veins
☐ Blood Clots	☐ Fibromyalgia	☐ Osteoporosis	☐ Vertigo / Dizziness
☐ Broken Bones	☐ Heart Problems	☐ Scoliosis	☐ Other: ________________

Injury and Surgical History: ____

____

____

Medications: ____

____

 Please continue on back side of this page.

CENTER MEDSPA CLIENT INTAKE FORM – MASSAGE THERAPY

Have you had a massage or body treatment before? ☐ No ☐ Yes Last Treatment: ____________________

Do you have difficulty lying down? ☐ No ☐ Yes Do you bruise easily? ☐ No ☐ Yes

Have you had a fever in the last 2 days? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes ____ mo.

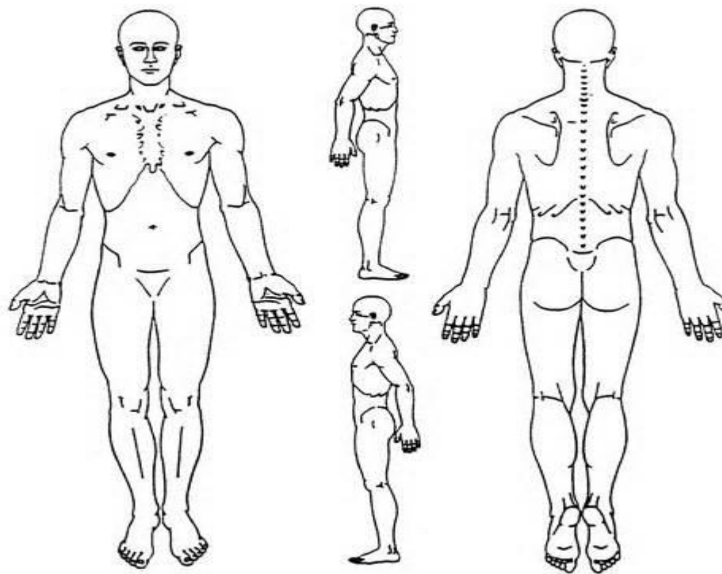
What are you main goals for this **Massage Therapy** session? Please check all that apply:

☐ Maintain Overall Wellness ☐ Control Headaches or Migraines ☐ Pain Relief
☐ Prevention ☐ Relieve or Manage Stress ☐ Soreness
☐ Relaxation ☐ Injury Recovery or Rehabilitation ☐ Spasms
☐ Stretching ☐ Part of a Physical Training Program ☐ Stiffness
☐ Other: ____

If you are receiving a **Body Treatment** today, what are you main goals for this session?

☐ Detox ☐ Firming / Toning ☐ General Wellness
☐ Exfoliation ☐ Relaxation ☐ Other: ____________

Please circle the areas of discomfort or concern:



I, _________________________ have completed this form to the best of my knowledge. I understand that massage services are designed to be a health aid and in no way take the place of a doctor's care when indicated. Because massage should not be performed under certain circumstances, medical conditions or symptoms, I understand that service may be refused; or in some cases, a referral may be required prior to receiving treatment. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status; it is to be used at my own discretion. I agree to keep the practitioner updated as to any changes and understand that there shall be no liability on the practitioner's part should I forget to do so. All information on this form or given verbally while in session is strictly confidential other than as required by law. Any release of this information cannot be granted without written consent. By signing below, I acknowledge that I fully understand and agree to the above information.

Signature: ____ Date: _______________________

(Signature of Client or Legal Guardian)