MASSAGE SPA

Client Intake Form

Client's Information

Full Name: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____ City: _____ ZIP Code: _____

E-mail: _____ Phone: _____

Emergency Contact

Full Name: _____

Phone: _____ Relationship: _____

Medical Information

Please check any of the following that apply to you:

☐ Headache / Migrane	☐ Arthritis (Osteo / Rheumatoid)	☐ Sciatica
☐ Fibromyalgia	☐ Joint Pain or Stiffness	☐ Sprains / Strains
☐ Cancer	☐ Back Pain	☐ Varicose Veins
☐ Chronic Fatigue	☐ Neck / Shoulder Tension	☐ Heart Conditions

☐ Other: _____

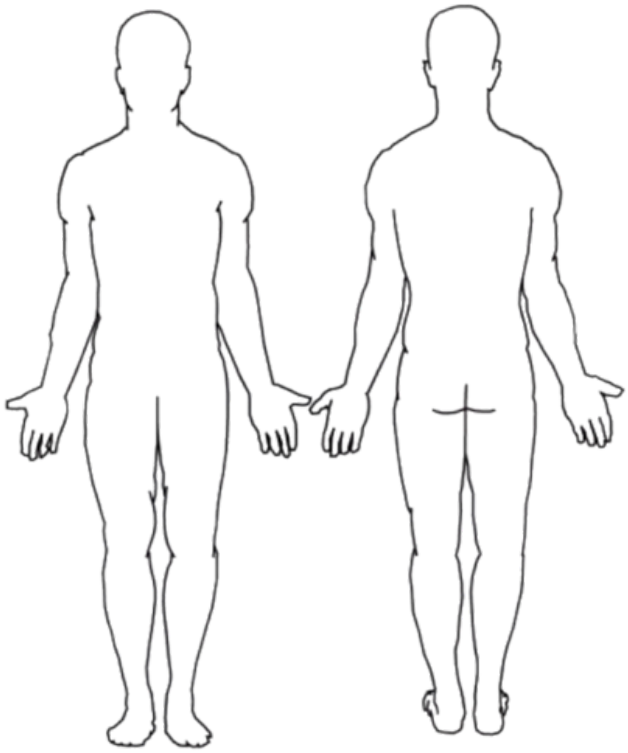
Are you currently pregnant? ☐ Yes ☐ No If yes, how far along? _____

Any Risk Factors? _____

Do you have any allergies or sensitivitys? ☐ Yes ☐ No If yes, please explain _____

_____

Please circle areas of discomfort



What areas would you like to focus on today?

_____

_____

_____

What type of massage are you seeking today?

- ☐ Swedish / Relaxation
- ☐ Therapeutic / Deep tissue

What pressure do you prefer?

- ☐ Light
- ☐ Medium
- ☐ Deep

Are there any areas you would NOT like massaged? (i.e. face, scalp, feet, etc). ☐ Yes ☐ No

If yes, please explain _____

What are your goals for this treatment session? _____

_____

_____

Consent and Agreement

I understand that the facial treatment is not a substitute for medical treatment or advice. I have provided accurate information to the best of my knowledge. I consent to the facial treatment and agree to follow the technician's recommendations for aftercare and skincare.

Client's Signature: _____

Date: _____

Technician's Signature: _____

Date: _____

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