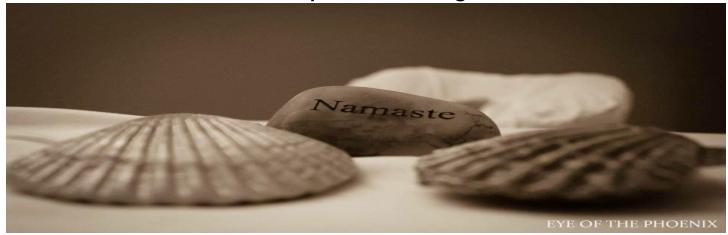
The Peace Within Spa & Wellness Center Client Intake Form Therapeutic Massage



Personal Information: Name
Phone (Day) Phone (Eve)
Address
City/State/Zip
Would you like to be on our E-mail list for sales & promotions? Please provide us with your e-mail address below:
Date of Birth_
Occupation
Emergency Contact Phone
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge. Date of Initial Visit
Have you had a professional massage before? Yes No If yes, how often do you receive massage therapy?
2. Do you have any difficulty lying on your front, back, or side? Yes No If yes, please explain
3. Do you have any allergies to oils, lotions, or ointments? Yes No If yes, please explain
4. Do you have sensitive skin? Yes No 5. Are you wearing contact lenses () dentures () a hearing aid ()? 6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe 7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe 8. 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 9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify

If yes, please explain

Circle any specific medical condition you may have:	
() phlebitis() deep vein thrombosis/blood clots() joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis() osteoporosis() epilepsy	
() headaches/migraines	
() cancer () diabetes	
() decreased sensation	
() back/neck problems	
() carpal tunnel syndrome () tennis elbow	
() pregnancy If yes, how many months?	
Medical History	
In order to plan a massage session that is safe and effective,	
I need some general information about your medical history. 11. Are you currently under medical supervision? Yes No	
If yes, please explain 12. Are you currently taking any medication? Yes No	
If yes, please list	
13. Please check any condition listed below that applies to you:	
() contagious skin condition () open sores or wounds	
() easy bruising	
() recent accident or injury	
() recent fracture () recent surgery	
() artificial joint	
() sprains/strains	
() current fever () swollen glands	
() allergies/sensitivity	
() heart condition	
() high or low blood pressure () circulatory disorder	
() varicose veins	
() atherosclerosis	
14. Is there anything else about your health history that you think would be us	seful for your massage practitioner to
know to plan a safe and effective massage session for you?	
15.Do you have any implants or recent surgeries? If yes please describe:	
Draping will be used during the session – only the area being worked on will be	De uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guard	ian during the entire session.
Informed written consent must be provided by parent or legal guardian for an	ny client under the age of 17.
I,understand that the massage I receiv	e is provided for the basic purpose of relaxation and relief
of muscular tension. If I experience any pain or discomfort during this session and/or strokes may be adjusted to my level of comfort. I further understand the	
medical examination, diagnosis, or treatment and that I should see a physicia	
mental or physical ailment that I am aware of. I understand that massage the	
adjustments, diagnose, prescribe, or treat any physical or mental illness, and be construed as such. Because massage should not be performed under cer	
known medical conditions, and answered all questions honestly. I agree to ke	
profile and	
understand that there shall be no liability on the therapist's part should I fail to	o do so.
Signature of client:	
Signature of Massage Therapist:	Date: