

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 _____

1. 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 _____

10. Do you have any particular goals in mind for this massage session? Yes No

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 useful 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 uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. 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: _____