Confidential
Client Intake Form – Therapeutic Massage

Serenity Spa & Wellness Center

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____ Referred by: _____

City/State/Zip _____

email _____ 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 _____

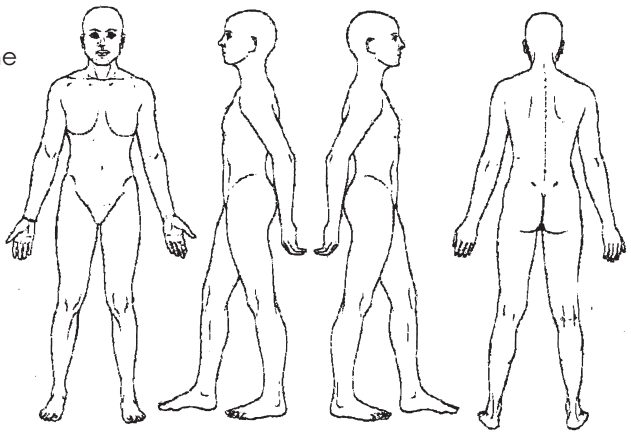
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any areas you do not want touched during your massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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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. Do you see a chiropractor? Yes No If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) easy bruising
( ) recent accident or injury
Date:_____
( ) recent fracture
( ) recent surgery
( ) allergies/sensitivity
( ) high or low blood pressure
( ) deep vein thrombosis/blood clots
( ) pregnancy If yes, how many months?
Delivery Date:_____
( ) joint disorder/rheumatoid arthritis/osteoarthritis

( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ

( ) contagious skin condition
( ) carpal tunnel syndrome
( ) phlebitis
( ) recent accident or injury
Date_____
( ) artificial joint
( ) sprains/strains
( ) artificial joint
( ) sprains/strains

Please explain any condition that you have marked above _____

_____

_____

15. 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? _____

_____

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,_____(Print name) I hereby authorize the therapists of Serenity Spa and Wellness Center to provide the appropriate thearapeutic treatments as they deem necessary through the use of relaxation techniques, precision neuromuscular therapy, therapeutic stretching, cupping, and diagnostic testing. I understand that some techniques may lead to minor muscle soreness. Cupping also may leave "marks" that may look like bruises. If the cupping results in any marks they will fade in 24 to 48 hours following the treatment. I realize the goal of wellness is to strengthen the patient's body in order to heal itself. 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 _____

NOTE: **Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our office.