SALON & SPA

Believe • Beyond • Be You

Date: ____________________

☐ Male ☐ Female

CLIENT INTAKE FORM - MASSAGE

Name ______________________________ Date of Birth ______________________________

Address ______________________________ City ______________________________

State ______________ Zip ______________ Email ______________________________

Phone ______________________________ Referral ______________________________

Emergency Contact ______________________________ EC Phone ______________________________

Physician ______________________________ Health Insurance Carrier ______________________________

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may not be beneficial. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? Yes No

If yes, how recently? ______________________________

If you circle 'Yes' to any of the following questions, please explain as clearly as possible in the Comments section:

Question			Question		
Do you frequently suffer from stress?	Yes	No	Do you suffer from epilepsy or seizures?	Yes	No
Do you have diabetes?	Yes	No	Do you suffer from joint swelling?	Yes	No
Do you experience frequent headaches?	Yes	No	Do you suffer from varicose veins?	Yes	No
Are you pregnant?	Yes	No	Do you have any contagious disease?	Yes	No
Do you suffer from arthritis?	Yes	No	Do you have osteoporosis?	Yes	No
Are you wearing contact lenses?	Yes	No	Do you have any allergies?	Yes	No
Are you wearing dentures?	Yes	No	Do you bruise easily?	Yes	No
Do you have high blood pressure?	Yes	No	Any broken bones in the past 2 years?	Yes	No
In an accident in the past 2 years?	Yes	No	Injuries in the past 2 years?	Yes	No
Do you have cardiac/circulatory problems?	Yes	No	Do you suffer from back pain?	Yes	No
Do you have nubness or stabbing pains?	Yes	No	Have you ever had major surgery?	Yes	No
Are you sensitive to touch in any area?	Yes	No	If yes, please specify: ______________		
Tension or soreness in specific areas?	Yes	No	If yes, please specify: ______________		

Comments: ____

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I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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/bodywork practitioners 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature ______________________________ Date ______________

Consent to Treatment of Minor: By signature below, I hereby authorize b Salon & Spa to Administer massage, bodywork or facial to my child or dependent as they deem necessary.

Signature of Parent or Guardian ______________________________ Date ______________

DATE	APPT.	NOTES	TECH.