MASSAGE (SPA) CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of   .
This form is used to collect information about new clients and used for internal purposes only. The information you provide is confidential and will be treated accordingly.

CLIENT INFORMATION

Name: ______________________ **Gender**: ☐ Male ☐ Female ☐ Other

Street Address: ____

City: ______________________ **State**: ______________________ **Zip Code**: ________

E-Mail: ______________________ **Phone**: ______________________

Emergency Contact: ______________________ **Phone**: ______________________

How did you hear about us?

☐ - Personal referral
☐ - Facebook/Instagram
☐ - YouTube
☐ - Online advertisement
☐ - Twitter
☐ - Yelp
☐ - Website/online search
☐ - Newspaper/Magazine

If you were referred, please provide their name: ________________________________

HEALTH INFORMATION

Are you taking any medications? ☐ Yes ☐ No

If yes, please list: ____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ Yes ☐ No

If yes, please list: ____

Are you pregnant? ☐ Yes ☐ No

If yes, how many months: _________________ Due date: ______________________

Are you currently under medical supervision or receiving other medical interventions? ☐ Yes ☐ No

If yes, please describe: ____

Do you have any of the following? (check all that apply)

- ☐ Areas of swelling
- ☐ Autoimmune disorder
- ☐ Back / neck problems
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Bruise easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Contagious condition
- ☐ Decreased sensation
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart condition
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Multiple sclerosis
- ☐ Neurological condition
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Sciatica
- ☐ Seizures
- ☐ Stroke
- ☐ Tendinitis
- ☐ TMJ disorder
- ☐ Varicose veins
- ☐ Vertigo / dizziness

Areas of broken skin? (e.g., rash, wounds) ☐ Yes ☐ No

If yes, where? ____

History of joint replacement surgery? ☐ Yes ☐ No

If yes, which joint(s)? ____

Recent injuries or medical procedures in the past 2 years? ☐ Yes ☐ No

If yes, please describe: ____

Please describe any other injuries or health conditions:

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

How recently? ____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please list and describe any areas of discomfort:

ACKNOWLEDGMENT & RELEASE

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

CLIENT SIGNATURE

Signature: ______________________ Date: ______________________

Print Name: ______________________