

Katrina's Thera~Spa Chair Massage Client Intake Form

Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Email _____

Are you interested in receiving our client newsletter? ___yes ___no

Are you experiencing any of the following:

Pain ___	Stress ___	Contagious skin disease ___	Osteoporosis ___	Joint disorder ___
Numbness ___	Allergies ___	Bruise Easily ___	Open Sores ___	Any other known condition ___
Stiffness ___	Cancer ___	Heart Condition ___	Headaches ___	

Please explain any of the above conditions you have checked _____

List current medications: (pain relievers) _____

Do you have any recent injuries or health issues? _____

Any recent accidents? _____

I have provided all related medical information. I understand that the purpose of this massage is for relaxation only. I understand that massage therapists will not provide medical diagnosis.

Signed: _____ Date: _____

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