

Katrina's Thera~Spa Client Intake Form – Therapeutic Massage

Personal Information:

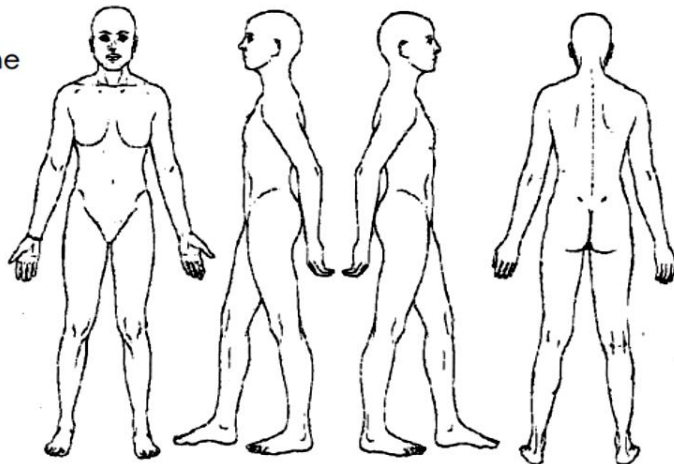
Name _____ Phone (Day) _____ Phone (Eve) _____
Address _____
City/State/Zip _____
Email _____ Date of Birth _____ Occupation _____
Emergency Contact _____ Phone _____

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 creams? _____
If yes, please explain _____
4. Do you have sensitive skin? Yes No
5. Are you wearing any contact lenses () dentures () a hearing aid ()?
6. Do you sit for long periods of time 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 daily life? Yes No
If yes, how do you think it has affected your health? Muscle tension () Anxiety () Insomnia () Irritability ()
Other _____
9. Is there a specific area of the body that you are experiencing tension, stiffness, pain, or other discomfort? Yes No
If yes, please describe _____
10. Please name 1-3 goals that you have for this session _____

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, please fill out 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(s)? Yes No

If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|---|
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Current fever /cold/other illness |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Decreased sensation |
| <input type="checkbox"/> Open sores or wounds | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Deep vein thrombosis/blood clots | <input type="checkbox"/> Back/Neck problems |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Allergies/sensitivity |
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Recent fracture | <input type="checkbox"/> TMJ (lock-jaw) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High or Low Blood Pressure |
| <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Carpal Tunnel Syndrome/Thoracic Outlet Syndrome |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Circulatory disorder |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Tennis Elbow/Golfer's Elbow |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Pregnancy If yes, how many weeks/months? _____ |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Joint disorder/rheumatoid -
arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> Diabetes | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful in planning 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 16 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 16.

I, _____ (printed name) 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 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: _____