***Client Intake Form***

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| ***Name: Date:*** | ***Occupation:*** |
| ***Address: City:*** | ***Date of Birth:*** |
| ***State: Zip Code: Phone: ( )*** | ***Would you like to receive our*** |
| ***E-mail: @*** | ***monthly newsletters*** *□ Yes □ No* |
| ***How did you hear about us?*** | ***Referral Name:*** |

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| *General Health* |
| 1. How would you describe your stress level? □ Low □ Medium □ High □ Very High |
| 1. Do you smoke/drink? □ Yes □ No How often? |
| 1. Do you wear contact lenses or glasses? □ Yes □ No |
| 1. Do you exercise regularly? □ Yes □ No How often? |
| 1. List any major injuries, accidents or surgeries: |
| 1. Do you have any metal implants, a pacemaker, or body piercings? |
| 1. List any medications you are currently taking: |
| 1. For Women: Are you pregnant? □ Yes □ No If yes, how many months? |
| BRIEF HEALTH HISTORY (check all that apply) |
| □ Heart Condition □ Lymph Edema □ Herpes/Shingles □ High/Low Blood Pressure □ Numbness/Tingling |
| □ Sinus Problems □ Allergies to scents or lotions □ Allergies in general □ Chronic Pain □ Sprains/Strains |
| □ Diabetes □ Gas/Bloating □ Headaches □ Arthritis □ Osteoporosis □ Varicose Veins □ Rashes □ TMJ |
| □ Blood Clots □ Poor Circulation □ Thyroid Dysfunction □ Spasms/Cramps □ Broken/Fractured Bones |
| □ Fatigue/Sleep Disorder □ Depression/Anxiety □ Cancer □ Seizures/Epilepsy □ Bruise Easily □ Sciatica |
| □ Fibromyalgia □ Asthma □ Disk Problems □ Scoliosis □ Stroke □ Infectious Disease |
| □ Flu/Cold symptoms in last 48 hours: |
| □ Other (explain): |
| massage therapy |
| 1. Have you had a professional massage before? □ Yes □ No How often? |
| 1. Reasons for massage therapy □ Relaxation □ Pain Relief □ Stress Reduction |
| 1. What type of pressure do you prefer? |

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| **SKIN CARE** |
| 1. Are you currently under care of a dermatologist? □ Yes □ No |
| 1. Have you used: □ Accutane □ Retin-A □ Renova □ Adapalene Hydroxyl Acid in the last 3 months |
| 1. Have you had: □ Chemical Peels □ Microdermabrasion □ Botox/Fillers □ Laser |
| 1. Please list your skin concerns: |
| 1. Do you have any skin sensitivities or irritants? |
| 1. What is your current daily cleansing regimen? |
| SKIN TYPE (check all that apply) |
| □ Oily/Congested □ Dry/Dehydrated □ Sensitive/Redness □ Acne □ Menopausal |
| Have you been diagnosed with □ Eczema, □ Psoriasis, □ Vitiligo or any other skin condition? |

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any 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 a Massage Therapist (MT) neither diagnoses illness, disease or any other medical, physical, or mental disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any ailment that I have. Because a MT must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations and I will inform the MT in writing of any change in my physical health. I understand that there shall be no liability on the practitioner part or Essentials Spa should I fail to do so. I also understand that any 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Consent to Treatment of Minor***: By my signature below, I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to administer massage, bodywork or facial to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_