

# Sandi's Body Spa

817.729.3055

In-take Form



## Client Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
*First Last Middle Month/Day/Year*

Address \_\_\_\_\_  
*Street City State Zip Code*

Phone Numbers \_\_\_\_\_ Occupation \_\_\_\_\_  
*Home Mobile Work*

Date of Birth \_\_\_\_\_ Referred by \_\_\_\_\_  
*Month/Day/Year Person's Name*

Email Address \_\_\_\_\_  
*Youremail@yourISP.com*

## Medical History

Have you had a professional massage before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any skin problems or allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have arthritis or any joint disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have varicose veins or blood clots?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any heart problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any spinal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your life style stressful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any significant changes in your life recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you presently taking any drugs or medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any medical condition that the therapist should know about?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a recent injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a recent surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you exercise or participate in any sport? If so, what kind and how often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List and Describe any Yes answers Injuries, Surgeries, Medications and Sports Activities

Check all that apply:

<input type="checkbox"/> Allergies to Lotion, oil, Fragrance	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pregnant due date _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Spinal Injury	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Tense Muscles
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Very Ticklish Spots
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Other
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Infection	

Describe

## Authorizations & Statements

The following questions must be addressed and documented client and therapist; please initial each question.

### Initial List of Questions

\_\_\_\_\_ I understand that if I become uncomfortable for any reason, I may ask the therapist to cease the massage and the session will end.

\_\_\_\_\_ I have submitted correct information regarding my state of health, medical history, injuries and surgeries.

\_\_\_\_\_ I am free of communicable disease and have not tested positive for HIV.

\_\_\_\_\_ I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder; the therapist will not prescribe medical treatment or pharmaceuticals, nor perform any spinal adjustments.

\_\_\_\_\_ 24-hour notice of cancellation is required. Failure to comply will result in your account being billed for the full amount of the session.



## Initial List of Questions

The following body parts will be avoided during the session:

I  DO  DO NOT want the therapist to massage my breasts. (check one)

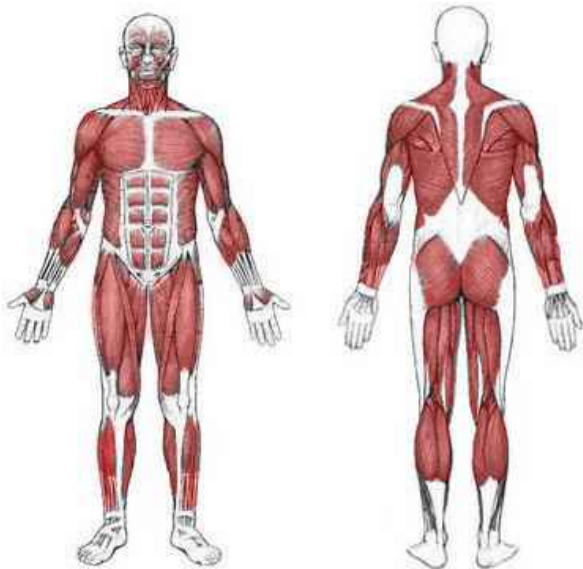
I prefer a  Towel  Sheet to be used as draping during the massage. (check one)

Type of massage techniques the therapist will use during the session:

- |                                             |                                             |                                                         |
|---------------------------------------------|---------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Esalen Style       | <input type="checkbox"/> Couples            | <input type="checkbox"/> Ear Candling                   |
| <input type="checkbox"/> Aroma Swedish      | <input type="checkbox"/> Chair Massage      | <input type="checkbox"/> Body Wrap                      |
| <input type="checkbox"/> Stress Relief      | <input type="checkbox"/> Lymphatic drainage | <input type="checkbox"/> Ionic Cleanse & Detox          |
| <input type="checkbox"/> Therapeutic Sports | <input type="checkbox"/> Prenatal           | <input type="checkbox"/> Body Scrub Cellulite Treatment |
| <input type="checkbox"/> Hot Basalt Stone   | <input type="checkbox"/> Foot Reflexology   | <input type="checkbox"/> Other                          |

Are you 18 years of Age? Parent or guardian signature required for minors.

Reason for treatment:



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Client or Guardian Signature

Date

Therapist Signature

Date