



MESSAGE INTAKE FORM

CLIENT INFORMATION

Name: _____ **Date** _____
Address: _____
City: _____ **State** _____ **Zip** _____
Cell # _____ **Other #** _____
Email _____ **Referred By** _____
Occupation _____ **Date of Birth** _____
How did you hear about us? _____
Emergency Contact _____ **Phone #** _____

MESSAGE HISTORY / SESSION INFORMATION

Have you ever had a professional massage? YES NO **Date of last massage** _____

What result do you want from your massage sessions? _____

List any exercise activities, including frequency: _____

MEDICAL CONDITION

Please mark any of the following you now have or have had:

- | | |
|---|---|
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Wear Contact Lenses |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Jaw Clenching/Teeth Grinding | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness/Tingling, If so, where? _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Varicose Veins | |

Injuries/accidents/illnesses still affecting you: _____

Surgeries: _____

Are you currently under the care of a health care practitioner? YES NO
If yes, specify purpose: _____

Arrival Time: _____

List current medications and purpose _____

Do you have any allergies and/or skin sensitivities? ___ YES ___ NO If yes, please list _____

Our lotions may contain nut oils. Are you allergic to nuts or nut products? ___ YES ___ NO

If yes, please list the types of nuts: _____

Are there any medical issues we should know about? If you have an issue you do not want to state on this form, please discuss it with your therapist.

*****Please note: Your hour session includes 5 minutes of preparation prior to massage and 5 minutes post massage to re-dress and consult with therapist. Session is 50 Minutes of Hands-On Massage (90 minute service will be 80 minutes of Hands-On)***

_____ ***Initial Here***

LEGAL INFORMATION

- If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the session may be adjusted to my level of comfort. I further understand that massage therapy should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of.
- I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
- I understand that any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.
- Should cancel or miss an appointment with less than 24 hours' notice, I authorize Willow Massage + Spa to charge me for the full session fee.
- I will not solicit, recruit or encourage any person employed by Willow Massage + Spa for employment or the provision of services outside this studio.
- By signing below, I hereby request and consent to the performance of hot stone massage in this or in future sessions. I understand that hot stone massage involves heating stones, then using those stones during the course of the massage, either by the massage therapist placing those stones on me to warm and relax muscles or by the massage therapist holding those stones in their hands and then massaging me with those stones. It is my sole responsibility to advise my therapist of my current medical conditions and to seek advice from a licensed medical professional to determine if hot stone therapy is safe for me. It is my responsibility to communicate with my therapist if I experience any discomfort or sensitivity during my session.

SIGNATURE: _____ **Date:** _____

THERAPIST SIGNATURE: _____ **Date:** _____