The Spa at Spring Ridge Client Intake Form – Therapeutic Massage

Name: _____ Phone (Day) _____ Phone (Eve) _____

Address: _____

City/State/Zip: _____

Email: _____ DOB: _____ 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 ointments? YES_____ NO_____

   If yes, please explain _____

4. Do you have any known allergies? YES _____ NO_____

   If yes, please explain _____

5. Do you have sensitive skin? YES _____ NO_____
6. Are you wearing: Contact Lenses ( ) Dentures ( ) a Hearing Aid ( )?
7. Do you sit for long hours at a workstation, computer or driving? YES _____ NO_____

   If yes, please explain _____

8. Do you perform any repetitive movement in your work, sports, or hobby? YES _____ NO_____

   If yes, please explain _____

9. Do you experience stress in your work, family or other aspect of your life? YES _____ NO _____

   If yes, how do you think it has affected your health?

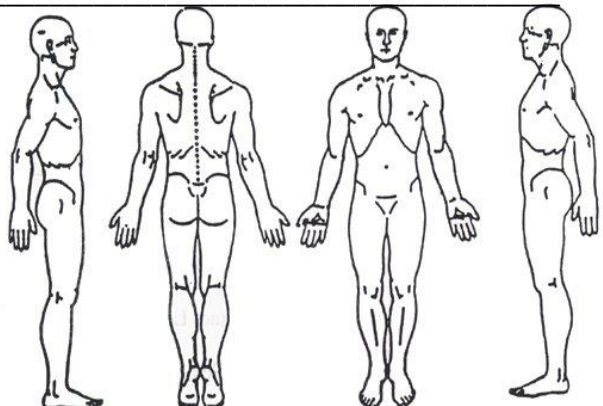
   Muscle Tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other _____

10. Is there a particular area of the body where you are experiencing tension, stiffness,

    pain or other discomfort? YES _____ NO _____

    If yes, please explain _____

Circle any specific areas you would like the Massage therapist to concentrate on During session



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