BELLEZA
SALON AND SPA

Massage Intake Form

The following information will be kept confidential:

Name: _____ Phone (H)_____ (W)_____ (C)_____

Address:_____City_____ST_____Zip_____

Date of Birth: _____Age _____Occupation _____

Email Address: _____

Emergency Contact: _____

1. Have you ever received a professional massage before? ○ Yes ○ No
2. Are you currently under the care of a health care practitioner? If yes, please explain: _____

   _____
3. Injuries/accidents/illnesses still affecting you: _____
4. Surgeries: _____
5. Are you pregnant? If yes, how many weeks? _____

Medical Profile

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

Musculoskeletal

○ Bone or joint disease ○ Fibromyalgia ○ Tendonitis/Bursitis ○ Lupus

○ Arthritis/Gout ○ Jaw Pain (TMJ) ○ Spinal Problems ○ Fractures

○ Sprains/Strains ○ Other: _____

Circulatory

○ Heart condition ○ Lymphedema ○ Phlebitis/Varicose Veins ○ Blood Clots

○ Thrombosis/Embolism ○ High/Low Blood Pressure ○ Other: _____

Respiratory

○ Breathing Difficulty/Asthma ○ Sinus Problems ○ Emphysema

○ Allergies (specify): _____ ○ Other: _____

Nervous System

O Shingles O Pinched Nerve O Epilepsy O Other: _____

Skin

O Allergies (specify): _____ O Rashes O Herpes/cold sores

O Athlete's foot O Other: _____

Digestive

O Irritable bowel syndrome O Ulcers O Other: _____

Other

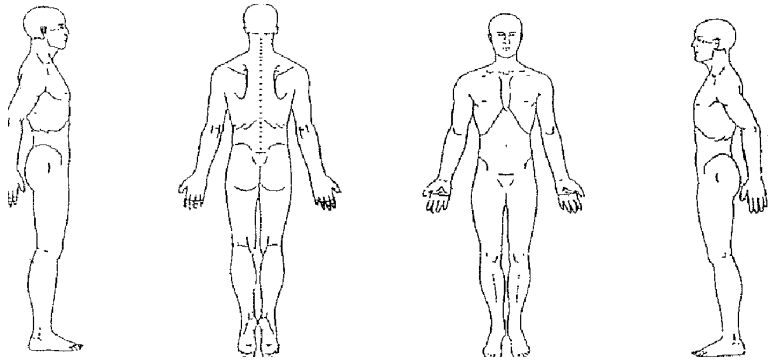
O Cancer/tumors O Bladder/kidney ailment O Diabetes O Fever O Chronic Pain

O Migraines/headaches O Depression O Anxiety/stress syndrome

Additional client remarks/comments

_____

Please indicate problem areas below:



Areas to avoid:_____ Areas of emphasis:_____

Clients under the age of 18 require informed written consent from their parent or legal guardian

Please read the following carefully and sign and date:

I _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief from muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted accordingly. 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 of which I am aware. 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 Parent/Legal Guardian (if applicable): _____