Newtown Massage and Spa Client Intake Form

Personal information

Name: _____

Phone number: _____Email:_____

Occupation:_____

Emergency contact name and number: _____

How did you hear about us? Print advert☐ Internet search☐ Groupon/SpinSaver☐

Event☐ Recommendation ☐ Other (please specify)☐:_____

Would you be interested in other services to help accomplish your goals?
(To find out more information from our front desk, check the service(s) of interest:
Personal Training ☐ Nutrition☐ Chiropractic☐ Physical Therapy☐

The following information will be used to help plan safe and effective massage sessions. Please answer the following questions to the best of your knowledge.

1.) Have you had a professional massage before? Yes No

If so, how often? _____

2.) Do you have any difficulty lying on your front, back or side? Yes No

If so, please explain: _____

3.) Do you have sensitive skin or allergies to oil, lotion, or ointment? Yes No

If so, please explain_____

5.) Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No If so, please identify: _____

6.) Are you currently under medical supervision? Yes No If so, please explain:_____

7.) Are you currently taking any medications? Yes No

If so, please list: _____

8. Select your options for your massage *(Please circle choices)*

Massage Pressure	Light Medium Firm Deep
Temperature	Table warmer: On / Off Fan: On / Off
Complimentary Aromatherapy	Yes (Visit front desk for scent options) No

Medical history

9.) (Check all that apply):

( ) Pregnancy (which trimester?)_____	( ) Lumbar spinal stenosis, spondylitis or spondylolisthesis
( ) Diabetes	( ) Scoliosis or lordosis; herniated discs (where?)_____
( ) High or low blood pressure (controlled?)_____	( ) Recent accident or injury (specify)_____
( ) Heart Condition (pacemaker?) _____	( ) Sprain/Strain/Fracture/Break
( ) Easy bruising	( ) Neuropathy (decreased sensation)
( ) Headaches/Migraines	( ) Surgery within the last year or implants within the last nine months (cheek, chin, breast, pectoral, calf)
( ) Circulatory disorder	( ) Current fever, flu, cold or swollen glands
( ) Open sores or wounds	( ) MRSA or other infectious diseases
( ) Phlebitis/Deep vein thrombosis/Blood clot/Varicose veins	( ) Epilepsy
( ) Fibromyalgia	( ) Atherosclerosis
( ) Joint disorder/Rheumatoid Arthritis/ Osteoarthritis/Tendonitis	( ) Aneurism
( ) Carpal tunnel	( ) Cancer (cancer medication?) _____
( ) Tennis/Golfer's elbow	( ) Kidney or liver disorder (including dialysis)
( ) TMJ	( ) Hemorrhoids
( ) Artificial joint	( ) Irritable bowel syndrome
( ) Osteoporosis	

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or stroke may be adjusted to my level of comfort. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that massage therapists are not licensed 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 change in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

A parent or legal guardian must accompany clients under the age of 18 and provide informed written consent. _____ Date: _____

Signature of client: _____ Date: _____

Signature of massage therapist: _____Date:_____

Massage Therapist Notes: _____

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