Peter Conte
salon and spa

Massage Intake Form

Name_____ **Telephone**_____

Address _____ **City** _____ **ST** _____ **Zip** _____

Your Occupation _____ **Date of Birth** _____

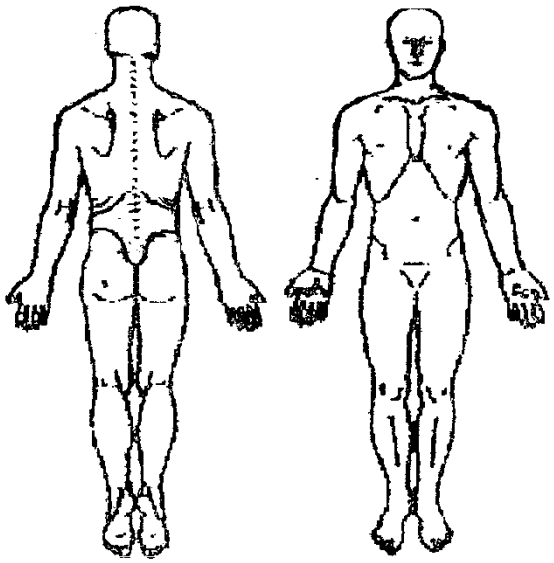
Emergency Contact _____ **Emergency Contact Telephone**_____

Are you in good health? ☐YES ☐NO
If no, explain: _____

Have there been any changes to your health in the past year? ☐YES ☐NO
If yes, explain: _____

Mark Appropriate Stress Zones

Mark as Follows:
X = Pain
O = Tension
*** = Injury**
≈ = Extra Attention Area



Are you currently taking any medication? ☐YES ☐NO
If yes, what?_____
Are you Pregnant? ☐YES ☐NO
If yes, what trimester are you in?_____
Do you suffer from allergies? ☐YES ☐NO
If yes, what?_____
Do you suffer from arthritis? ☐YES ☐NO
Do you have uncontrolled blood pressure? ☐YES ☐NO
Do you have varicose/ spider veins? ☐YES ☐NO
If yes, where?_____
Have you ever had any Lymph nodes removed?☐YES ☐NO
If yes, where?_____

Do you bruise easily? ☐YES ☐NO
Do you have any blood disorders? ☐YES ☐NO
If yes, explain_____
Do you have a heart disorder? ☐YES ☐NO
If yes, explain_____
Are you on any over the counter meds? ☐YES ☐NO
If yes, what?_____
Do you wear contact lenses? ☐YES ☐NO
Have you had cancer? ☐YES ☐NO
If yes, when/where/what kind & explain treatment_____
_____
_____

~*~OVER PLEASE~*~

Have you ever had surgery? ☐YES ☐NO

If yes, where, when and why? _____

_____

Have you ever received a Massage Before? ☐ YES ☐ NO

If yes, when was your last massage? _____

Have you consumed an alcoholic beverage within the last 12 hours? ☐ YES ☐ NO

Do you have any other Injury/ Illnesses that your Therapist should be aware of? ☐YES ☐NO

If yes, explain: _____

_____

If there is anything that you feel your therapist should know, but has not been addressed with the above questions? Please use the following spaces to explain:

_____

_____

_____

_____

Informed Consent: The above information is accurate to the best of my knowledge, and I give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand that this is not a medical treatment and this session is not a substitute for any medical diagnosis, treatment, or examination. I understand that no inappropriate comments or conduct, by client will be tolerated, and that any indication of such will automatically end the session and will be charged the full amount of the scheduled service. I further understand that massage will be administered at the discretion of the therapist and any medical condition contraindicated to massage will disqualify me from receiving a massage, unless a Doctors note is furnished.

X_____ _____

Massage Recipient's Signature **Date**

_____ _____

Therapist's Signature **Date**

Date	Comments	Therapist