GetAway Massage & Spa

Therapeutic Massage - Confidential Client Intake Form

Personal Information

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____ Occupation: _____ o Male o Female

Emergency Contact: _____ Phone (_____) _____ Physician _____

Massage Information

How did you hear about us? _____

Have you ever had professional massage before? o Yes o No How recently? _____

What kind of pressure do you prefer? o Light o Medium o Firm

What type of massage are you seeking today? o Relaxation o Deep Tissue/Therapeutic o Pregnancy

o Sports o Energy Work o Integrated Bodywork o Other _____

Are you sensitive to fragrances or perfumes? o Yes o No

If yes, what? _____

Do you have sensitive skin? o Yes o No

Do you wear contact lenses? o Yes o No

Do you exercise regularly? o Yes o No

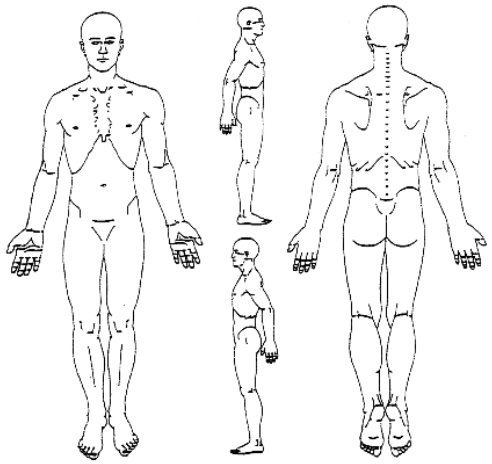
If so, what type(s)? _____

_____

What are your common areas of pain or tension?

_____

_____



Please use the body diagrams to the right to indicate any areas you would like the massage therapist to concentrate on.

Medical History

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided

Do you suffer from chronic or persistent pain/discomfort? _____ If so, for how long? _____

Do you know what caused it/what makes the symptoms better or worse? _____

Do you see a chiropractor? o Yes o No If so, how often? _____

Are you currently under medical care? o Yes o No

Signature

GETAWAY
MASSAGE & SPA

INTAKE FORM

Health History: Please mark any of the following that pertain to you

Headaches/migraines ____
Vertigo/Dizziness ____
Asthma ____
Chronic Cough ____
Shortness of Breath ____
Fever ____
Frequent colds ____
Smoker ____

Sciatica ____
Seizures ____
Numbness/Tingling ____
Epilepsy ____

Arthritis ____
Osteoporosis ____
Bursitis ____

High Blood Pressure ___
Low Blood Pressure ___
Poor Circulation ___
Pacemaker ___

Tuberculosis ___
Herpes ___
HIV / AIDS ___
Infectious skin condition ___

Diabetes ___
Cancer ___
Fibromyalgia ___
Anxiety ___
Other conditions:_____
_____
_____

Have you traveled last 14 days? Y / N
Have you been asked to self quarantine last 14 days? Y / N
Have you experienced any cold like symptoms in the last 14 days? Y / N

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.
I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.
I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.
I understand that close contact with people increases the risk of infection from COVID-19. By signing below I acknowledge that I am aware of the risks involved and give my consent to receive massage from this practitioner.

Signature: _____ Date: _____