Essentials Massage & Facials

MASSAGE INTAKE FORM

Name: _____ D.O.B: _____
Contact Number: _____ Email: _____
We offer text message confirmation. If you'd like to sign up we'll need your service provider: _____
Address: _____ Apt. # _____ City/Zip: _____
Emergency Contact Name:_____ Emergency Number:_____

Are you pregnant? □ Yes □ No **How far along?** _____
What is the reason for your visit today? _____
Have you ever had a massage before? □ Yes □ No
What are your other health concerns? _____
List any major injuries/surgeries: _____
_____
_____
_____
List any accidents you have had: _____
_____
_____
List all conditions currently monitored by a Health Care Provider: _____
_____
List any medications that you currently take: _____
_____
_____

MEDICAL HISTORY

Check any or all that apply to your current health:

___ headaches
___ asthma
___ sinus problems
___ jaw pain/teeth grinding
___ fatigue
___ depression
___ sleep difficulties
___ broken bones
___ disk problems
___ allergies to scents or lotions
___ allergies, in general
___ poor circulation
___ thyroid dysfunction
___ muscle or joint pain
___ numbness/tingling
___ sprains/strains
___ scoliosis
___ arthritis
___ tendonitis/bursitis
___ spinal problems
___ seizures
___ spasms/cramps
___ stroke
___ heart disease
___ varicose veins
___ blood clots
___ high/low blood pressure
___ diabetes
___ benign cancer/tumors
___ malignant cancer/tumors
___ infectious disease
___ skin problems
___ osteoporosis
___ sciatica
___ pace maker
___ flu/cold symptoms in last 48 hours

_____ I agree to the Essentials Massage & Facials 24 hour cancellation policy, and will pay the full appointment fee.
(Initials)

I give consent to receive treatment at Essentials Massage & Facials. I understand I will be receiving a professional service from a licensed specialist. I understand the benefits and risks of massage and give my consent for massage. I will consult my therapist with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my therapist informed of any changes. I also agree there will be no liability on the therapist's part or Essentials LLC for any services rendered.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____