



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Do NOT use this intake form for Medical Massage or Facials

Relaxation/Therapeutic Massage Intake Form

General Information	
First Name: _____ Last Name: _____ Address: _____ Apt: _____ City: _____ State: _____ Zip: _____ Current / Previous Occupation: _____	Date of Birth ____/____/____ Cell Phone: (____) _____ <input type="checkbox"/> <i>Opt-in your cell phone to receive text alerts</i> Gender (circle one): Male OR Female Email: _____
Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____	How'd you hear about us? (So, we can give credit) Full Name of Referral: _____

Groupon Redemption Code <i>(7-8 numbers under barcode)</i>	Spa Finder / Spa Week OR Somatic Gift Certificate #
____/____/____/____/____/____/____/____	_____

Service Enhancements Ala Carte (Non-Members Rate)			
<u>CIRCLE YOUR SELECTIONS</u>			
<i>(For More Details on Each Enhancement Service Check the Back of this Clipboard)</i>			
\$15	Pomegranate & Açai Berry Sugar <i>FOOT</i> Scrub	\$10	CBD Massage Balm 660mg
\$25	Pomegranate & Açai Berry Sugar <i>BACK</i> Scrub	\$20	Lace your Face Clinical Grade Compression Mask
\$25	CBD & Mint Sugar <i>FOOT</i> Scrub	\$12	Luminous Eye Lift Collagen Choose: Caffeine OR 24k Gold
\$35	CBD & Mint Sugar <i>BACK</i> Scrub	\$35	Steam Therapy Detox Tent <i>(REQUIRES ADDITIONAL 30 MIN)</i>
\$10	Hand Lavender Paraffin	\$45	Herbal Steam Therapy Detox Tent <i>(REQUIRES ADDITIONAL 30 MIN)</i>
\$25	Rapid Tension Relief (RTR) Therapy <i>(REQUIRES ADDITIONAL 10 MIN)</i>	\$45	Deep Tissue or Firm Pressure
\$10	Aroma Therapy	\$35	Hot Stone Therapy





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Massage Information

Is this your first professional massage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, how frequently do you get a massage? _____	
Do you have any chronic, ongoing pain that you deal with on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware of any tension holding spots in your body?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Information

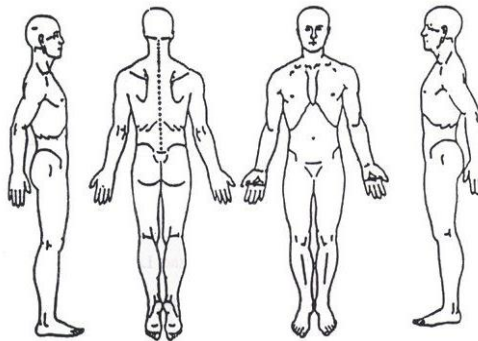
Do you have any sensitivity to heat or cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any allergies or sensitivity to smells, oils, lotions, or ointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any skin conditions or rashes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any chronic, ongoing pain that you deal with on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any difficulty lying on your front, back or side? If yes where: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you see a chiropractor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently Pregnant? If yes, How many months? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any recent surgeries or broken bones? If yes, what kind or where: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Area(s) you would like your therapist to avoid:

Area(s) you would like your therapist to focus on:

What do you hope to accomplish from today's massage?

Please Circle Any Areas of Discomfort:



Circle (choose one)

What pressure do you prefer? (CIRCLE ONE)

1. Light
2. Medium
3. Firm/ Deep (ADDITIONAL PRICE)
See add-on services section

1-5 with 5 being the most, what is your stress level today? (CIRCLE ONE)

1 2 3 4 5

1-5 with 5 being the most, what is your pain level today? (CIRCLE ONE)

1 2 3 4 5

I, the undersigned patient, understand, acknowledge and agree that: (i) I am aware the facilities and services offered by Somatic Massage Therapy, P.C. involves risk. (ii) I have provided all relevant information regarding my current health status. (iii) I am seeking the Spa/Medical Massage services at my own free will; and (iv) I assume all risk associated therewith. On behalf of myself and my heirs I hereby release and discharge Somatic Massage Therapy, P.C. (the "Owner") and all of their affiliates, employees, contractors, directors, officers, agents, landlords, representatives, successors and assigns of the owner from any and all claims or causes of actions arising out of or relating to spa services. Including but not limited to, those resulting from bodily injury, theft, loss of, or damage to property of mine unless due to the gross negligence of willful misconduct of Somatic Massage Therapy, P.C., its owner or employees/contractors. I, further, fully understand, acknowledge and agree all spa services are provided exclusive as a convenience to me by Somatic Massage Therapy, P.C. & I accept the service(s) at my own risk and expense without liability or responsibility to the Spa or its affiliates. The above information is accurate & true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours' notice (medical emergencies excluded) will be charged \$50 & complete NO-SHOW will be charged 100% of full-service price.

Signature: _____ Date: _____/_____/_____ Practitioners Initials: _____