

Client Intake Form and Confidential Health History

Healing Palms Spa

Name _____ Address _____

Phone _____ Email address _____ Birthday ____/____/____

Family Doctor _____ Emergency Contact/ Phone# _____

How did you hear about us? (Circle one) radio shopper magazine newspaper friend

(List friends name) _____

Have you ever had a massage before? Yes/no if yes, when was your last one? _____

Are you ticklish or sensitive to pressure? Yes/no Do you have pain or numbness? Yes/no

What Medications are you taking? _____

What are your expectations for your session? _____

Occupation: _____ Have you had surgery in the last 3 years? If yes, please describe _____

Indicate if you would like massage on these areas: Feet __Y__N Glutes __Y__N Pectorals __Y__N Abdomen __Y__N

Please indicate below if you are currently experiencing any of the following: Y for yes or N for no.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Migraines/headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Bruises/cuts/wounds
<input type="checkbox"/> Back problems	<input type="checkbox"/> Disk Degeneration	<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Pregnant: Trimester 1 2 3
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Epilepsy/seizure	<input type="checkbox"/> Shingles	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Sprains/Fractures	<input type="checkbox"/> Other (please list)

Please read the following information, your signature indicates you have read, understand and agree to the terms below.

1. I understand the massage or body services I receive are for relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately notify my therapist so the massage may be adjusted to my comfort level. I am free from any contagious disease/illness at this time & if not, I will reschedule my appointment.
2. I understand these therapies are not a substitute for medical examination, diagnosis, or treatment. I understand the therapist is not qualified to perform spinal or skeletal adjustments, diagnose an illness, prescribe medication, or treat any physical or mental illness.
3. Because massage should not be done under certain conditions, I confirm I have stated all my known medical conditions and shall hold Healing Palms Spa, staff and Independent contractors of the Spa free from liability of injury while on the premises.
4. Payment in full will be rendered at the time of the service. I understand that accepted forms of payment are Cash, Visa, MasterCard, Discover, Austin Chamber Dollars, Check(with valid driver's license), Spa Wish Gift Cards & Spa Finder Gift Cards.
5. I will notify Healing Palms Spa 24 hours in advance if I need to reschedule my appointment. If I fail to do so, Healing Palms Spa will bill me for the session and I agree to pay them in full.
6. I clearly understand that Healing Palms Spa provides professional massage services according to the law, and that no sexual remarks or advances will be tolerated, and the result of such behavior will result in immediate termination of my session and I will pay for this session in full. Healing Palms Spa reserves the right to refuse service to anyone.

Client Signature

Date

Therapists Signature

Date

Indicate areas you would like your therapist to address on the diagram below if applicable.

