Sandi's Body Spa

817.729.3055

In-take Form

Client Information

Name _____ Date _____
First Last Middle Month/Day/Year

Address _____
Street City State Zip Code

Phone Numbers _____ Occupation _____
Home Mobile Work

Date of Birth _____ Referred by _____
Month/Day/Year Person's Name

Email Address _____
Youremail@yourISP.com

Medical History

Have you had a professional massage before?	❑ Yes	❑ No
Do you have any skin problems or allergies?	❑ Yes	❑ No
Do you have arthritis or any joint disorders?	❑ Yes	❑ No
Do you have varicose veins or blood clots?	❑ Yes	❑ No
Do you have any heart problems?	❑ Yes	❑ No
Do you have any spinal problems?	❑ Yes	❑ No
Do you have headaches?	❑ Yes	❑ No
Do you have problems sleeping?	❑ Yes	❑ No
Is your life style stressful?	❑ Yes	❑ No
Have you had any significant changes in your life recently?	❑ Yes	❑ No
Do you smoke?	❑ Yes	❑ No
Are you presently taking any drugs or medications?	❑ Yes	❑ No
Do you have any medical condition that the therapist should know about?	❑ Yes	❑ No
Have you had a recent injury?	❑ Yes	❑ No
Have you had a recent surgery?	❑ Yes	❑ No
Do you exercise or participate in any sport? If so, what kind and how often?	❑ Yes	❑ No

_____

List and Describe any Yes answers Injuries, Surgeries, Medications and Sports Activities

Check all that apply:

- ❑ Allergies to Lotion, oil, Fragrance
- ❑ Arthritis
- ❑ Cancer
- ❑ Heart Problems
- ❑ Low Blood Pressure
- ❑ Sciatica
- ❑ Blood Clots
- ❑ Diabetes
- ❑ Bursitis
- ❑ Spinal Injury
- ❑ Migraine Headaches
- ❑ High Blood Pressure
- ❑ Epilepsy
- ❑ Infection
- ❑ Pregnant due date _____
- ❑ Skin Problems
- ❑ Varicose Veins
- ❑ Tense Muscles
- ❑ Very Ticklish Spots
- ❑ Other

_____
Describe

Authorizations & Statements

The following questions must be addressed and documented client and therapist; please initial each question.

Initial	List of Questions
_____	I understand that if I become uncomfortable for any reason, I may ask the therapist to cease the massage and the session will end.
_____	I have submitted correct information regarding my state of health, medical history, injuries and surgeries.
_____	I am free of communicable disease and have not tested positive for HIV.
_____	I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder; the therapist will not prescribe medical treatment or pharmaceuticals, nor perform any spinal adjustments.
_____	24-hour notice of cancellation in required. Failure to comply will result in your account being billed for the full amount of the session.

Sandi Rosier
Registered Massage Therapist

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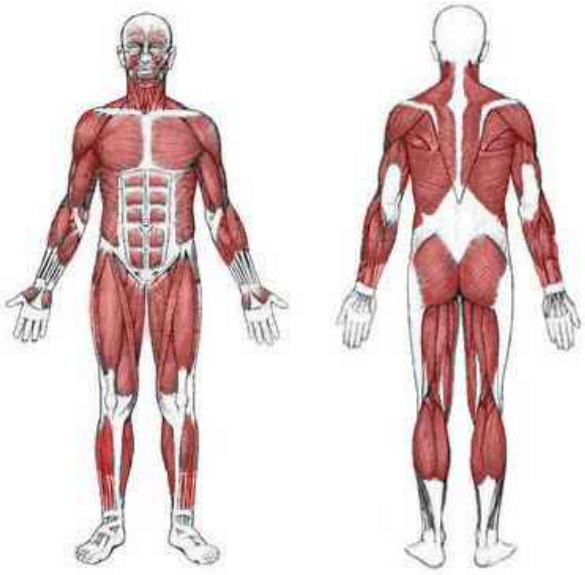
Initial	List of Questions
	The following body parts will be avoided during the session:
	I ❑ DO ❑ DO NOT want the therapist to massage my breasts. *(check one)*
	I prefer a ❑ Towel ❑ Sheet to be used as draping during the massage. *(check one)*
	Type of massage techniques the therapist will use during the session:

- ❑ Esalen Style
- ❑ Aroma Swedish
- ❑ Stress Relief
- ❑ Therapeutic Sports
- ❑ Hot Basalt Stone
- ❑ Couples
- ❑ Chair Massage
- ❑ Lymphatic drainage
- ❑ Prenatal
- ❑ Foot Reflexology
- ❑ Ear Candling
- ❑ Body Wrap
- ❑ Ionic Cleanse & Detox
- ❑ Body Scrub Cellulite Treatment
- ❑ Other

Are you 18 years of Age? *Parent or guardian signature required for minors.*

Reason for treatment:



Client or Guardian Signature Date

Therapist Signature Date

Sandi Rosier
Registered Massage Therapist