

Therapist's Name: \_\_\_\_\_

**MASSAGE INTAKE FORM**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Best time to follow up on your session: AM / PM / Evening      How did you hear about us? \_\_\_\_\_

Reason/Expectations for this appointment:       Relaxation,       Pain Relief/Therapeutic

How often do you seek massage?  1x per week    1x per month    2x per month    Other \_\_\_\_\_

What do you look for when scheduling an appointment?  Time    Cost    Convenience    Therapist Preference

Is this a gift (Birthday, Anniversary, etc.)?    Yes    No

What Pressure do you prefer?    Light    Medium    Firm    Deep

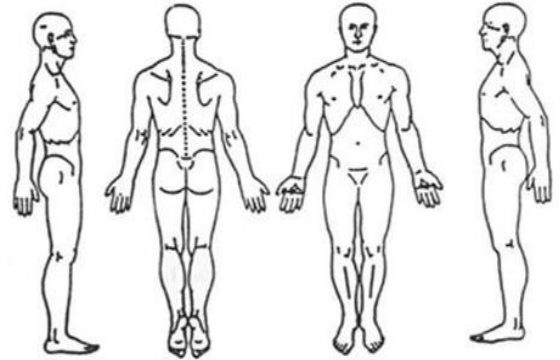
Please Mark  for area that you want your therapist to focus on.

Mark **X** for the area you want them to avoid:

**We Do Not Massage Breast, Abdomen, Private Areas**

**Please indicate if any of the following applies to you:**

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |



Explain any condition(s) you have marked above: \_\_\_\_\_

**Please indicate if any of the following applies to you:**

Do you frequently suffer from extreme stress?    Yes    No

Have you suffered any accidents or injuries in the past that prevent you from getting a massage?    Yes    No

Have you ever had surgeries that prevent you from getting a massage?    Yes    No

Have you had any broken bones in the past two (2) years to prevent you from getting a massage?    Yes    No

**Are you pregnant?**    Yes    No   **If yes, how many weeks?** \_\_\_\_\_

Are you taking any medication that will prevent you from getting massage(s)?    Yes    No   \_\_\_\_\_

Do you have any contagious diseases?    Yes    No   If yes, please specify: \_\_\_\_\_

Are you sensitive to touch or pressure anywhere?    Yes    No   If yes, please specify: \_\_\_\_\_

**THIS SECTION IS FOR THE FRONT DESK ASSOCIATES ONLY**

Service Scheduled: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

SA Name \_\_\_\_\_ Time Taken in \_\_\_\_\_

SA NOTE: \_\_\_\_\_

- Hot Stones:**
- Hot Herb Pack:**
- Pain Relief Balm**
- Aromatherapy:**
- Sugar Foot Scrub:**
- Sugar Hands Scrub:**
- Peppermint Scalp**
- White Flower Balm**
- Cold Stone Face**
- Herbal Foot Spa**

**PLEASE READ THE FOLLOWING STATEMENT IN DETAIL, THEN SIGN BELOW.**

I am aware that **draping** will be used during the massage session and I understand that it is **NOT** within the scope of the massage session for the therapist to engage in massage on **breasts, abdomen, or private area**. I also understand that my feedback is an essential element in my treatment, **if I should feel uncomfortable for any reason after my session started; I am to bring it to the therapist's / Front Desk attention and request for the session to end immediately. I will be charged for the full service(s) fee if I didn't stop the session within 20 minutes of my session starting. I can either change another service provider to suit my request or no charge to my 20 minutes session.**

The massage treatment given at All is Well Massage & Spa is for the sole purpose of stress reduction, relief from muscle tension or spasm, and to increase circulation and energy flow, for relaxation and therapeutic purposes only.

**There is absolutely NO sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity and you will be treated the same in return. Our company has zero tolerance to the inappropriate touch or sexual assault. If you believe you experienced any of our service provider's inappropriate touch or sexual assault or any attempt, you shall stop the service and walk out the room and report to the management immediately.**

The Massage Therapists at All is Well SPA do not diagnose or prescribe for medical illnesses, disease, or any other physical or mental disorder. Nothing said during the session should be construed as such. The Massage Therapists do not do spinal manipulations. Massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have. It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist before you start your session so that the Therapist may do their job. **Your Massage Therapist is only responsible for your massage treatment.**

I agree to hold All Is Well Massage & Spa, its therapists, or any individual at said institution free of any responsibility as to my physical condition before or after having received the usual and customary massage service offered by said institution, whether said service is one or more than one.

**I agree not to solicit the therapist or utilize the services of the Company's therapists other than inside All is Well Massage and Spa facility.**

**I understand that All Is Well Massage and Spa's Late Arrival Policy: if I'm late to my session, I will only get the remaining of the scheduled time.**

**I understand that All Is Well Massage & Spa reserves the right to refuse services to anyone.**

I have read and fully understand this form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify my therapist, and update this form before receiving additional massages.

**Client's Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

**Therapist's Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

**Consent to Treatment of Minor: By my signature below, I hereby authorize All Is Well Massage & Spa Therapist to administer massage therapy to my child or dependent as they deem necessary.**

Parent or Guardian's Name (Print) \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_