

NEW CLIENT MASSAGE INTAKE FORM

First Name: _____ Last Name: _____ Date of Birth: _____

Occupation: _____ (this will help us to diagnose the cause of your tension, stress, or pain)

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 indicate if any of the following applies to you:

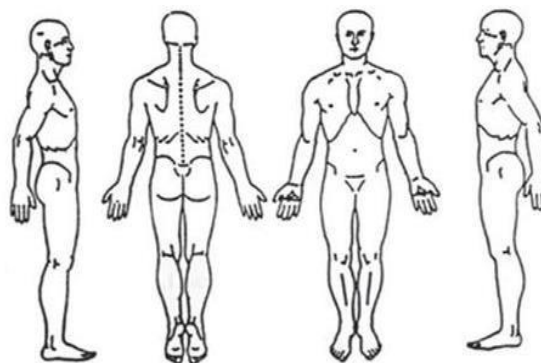
- | | |
|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <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 Mark for the area that you want your therapist to focus on.

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

NO Massage on Breast, Abdomen, Private



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 prevented 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: _____

Below add on are the therapists special add on modalities.

Back Walking/Thai \$20 Fire Cupping \$30 Prenatal

Herbal Foot Spa \$15 Lymphatic Drainage \$20 Gua Sha \$30

Elite Therapist Upcharge \$30 Medical Massage \$20

THIS SECTION IS FOR THE FRONT DESK ASSOCIATES USE ONLY

Service Scheduled: _____

Appointment Time: _____ AM /PM Checked in Time _____

Session Started Time: _ SA Name: _____

- | | | |
|-------------------------|------|--------------------------|
| Aromatherapy | \$10 | <input type="checkbox"/> |
| Aloe Cube Face Massage | \$15 | <input type="checkbox"/> |
| Cold Stone Face Massage | \$15 | <input type="checkbox"/> |
| Cool Cucumber Face Mask | \$10 | <input type="checkbox"/> |
| Hot Stones | \$15 | <input type="checkbox"/> |
| Hot Towels | \$10 | <input type="checkbox"/> |
| Tiger Balm | \$15 | <input type="checkbox"/> |
| Herbal Pain Relief Balm | \$15 | <input type="checkbox"/> |
| Mini Facial Gua Sha | \$15 | <input type="checkbox"/> |
| Sugar Foot Scrub | \$15 | <input type="checkbox"/> |
| Sugar Hands Scrub | \$15 | <input type="checkbox"/> |
| Peppermint Scalp | \$15 | <input type="checkbox"/> |
| White Flower Balm | \$15 | <input type="checkbox"/> |

Please read the following statement in detail and sign below:

I am aware that **draping will be used** during the massage session, and I understand that the therapist will not perform massage on the **breasts, abdomen, or private areas**. I also understand that my **feedback is essential** to my treatment. If I feel uncomfortable for any reason after my session begins, I will bring it to the therapist's or front desk's attention and request the session to **end immediately**. I will be charged the **full-service fee** if I don't stop the session within **20 minutes** of its start. I can either change to another service provider or receive no charge for the 20-minute session.

Massage treatments at All Is Well Holistic Spa are for the sole purposes of **stress reduction, relief from muscle tension or spasms, and increasing circulation and energy flow** for relaxation and therapeutic purposes only. There is **absolutely no sexual component** to massage. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of the session and refusal of all future services. You will be charged the **full-service fee** regardless of the session length. Depending on the behavior exhibited, we may also file a report with **local authorities** if necessary. Treat your therapist with respect and dignity, and you will be treated likewise. Our company has **zero tolerance for inappropriate touch or sexual assault**. If you believe any service provider engaged in inappropriate touch, sexual assault, or an attempt thereof, stop the service, leave the room, and report to management immediately.

Massage therapists at All Is Well Holistic Spa do not **diagnose or prescribe** for medical illnesses, diseases, or other physical or mental disorders. Nothing said during the session should be interpreted as such. Massage therapists do not perform **spinal manipulations**. Massage therapy is not a substitute for **medical examination or diagnosis**, and it is recommended that a physician be consulted for any ailment you may have. It is the client's responsibility to discuss all physical conditions with the massage therapist before starting the session so that the therapist can perform their job effectively. Your massage therapist is only responsible for your **massage treatment**.

I agree to hold All Is Well Holistic Spa, its therapists, or any individual at this institution free of responsibility for my physical condition before or after receiving the usual and customary massage service, whether this service is one or more than one.

I agree not to solicit the therapist or use the company's therapists' services outside of the All Is Well Holistic Spa facility.

I understand the **late arrival policy**: If I'm late for my session, I will only receive the remaining time of the scheduled appointment.

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

I have read and fully understand this form. If my information or condition changes, I will notify my therapist and update this form before receiving additional messages.

Client's Signature: _____

Date: _____ 202_____

Therapist's Signature: _____

Date: _____ 202_____

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: _____