CASSIA'S
Elegant Spa

Massage Intake Form

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Personal Information

Name _____ Phone (day) _____ (evening) _____
Address _____ City State Zip _____ DOB* _____
Occupation _____ Employer _____
Email _____ Primary Physician _____
Emergency Contact _____ Relationship _____ Phone _____
How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no
If yes, please list names and how administered: _____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____
Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____
What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Bulging herniated disk
- ☐ Arthritis
- ☐ o Diabetes
- ☐ O Surgeries
- ☐ Bruise easily
- ☐ Neuropathy
- ☐ Infection
- ☐ Stroke
- ☐ Heart Attack
- ☐ Seizures
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above: _____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

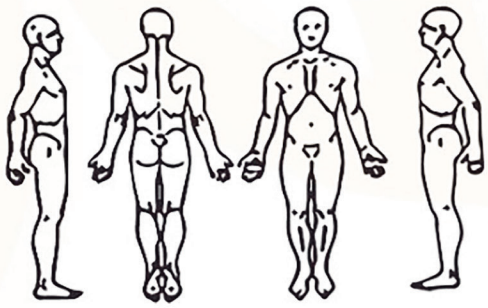
☐ Relaxation ☐ Therapeutic /Deep Tissue
Other _____
What pressure do you prefer?
☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____
Are there any areas (foot, face, abdomen, etc) you do not want massaged? ☐ yes ☐ no

Please explain _____
What are your goals for this treatment session? _____

Please circle any areas of discomfort



By signing below you agree to the following
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____
Therapist Signature _____ Date _____