Amb Day Spa
Inspiring Wellness

Confendential Client Intake Form

Name: _____Date_____

Address: _____City:_____ Zip: _____

E-mail: _____

May we contact you via mail/email about future promotions and news? □ Yes □ No

Birth date: _____ Occupation _____

Phone: _____ Referred by:_____

Emergency contact: _____Phone: _____

How did you hear about Amb Day Spa:_____

GENERAL & MEDICAL INFORMATION

Have you ever received a professional massage? YES NO How recently? _____

What type of massage do you prefer? LIGHT MEDIUM FIRM OTHER _____

Are you sensitive to scents: YES NO

Do you have any allergies to oils, Lotions, or ointments? YES NO

Check areas of your body that you do NOT want to receive massage:

___ Abdomen ___ Chest muscles ___ Face ___ Feet ___ Glutes ___ Scalp

Are you wearing: contact lenses **( )** dentures **( )** a hearing aid **( )** ?

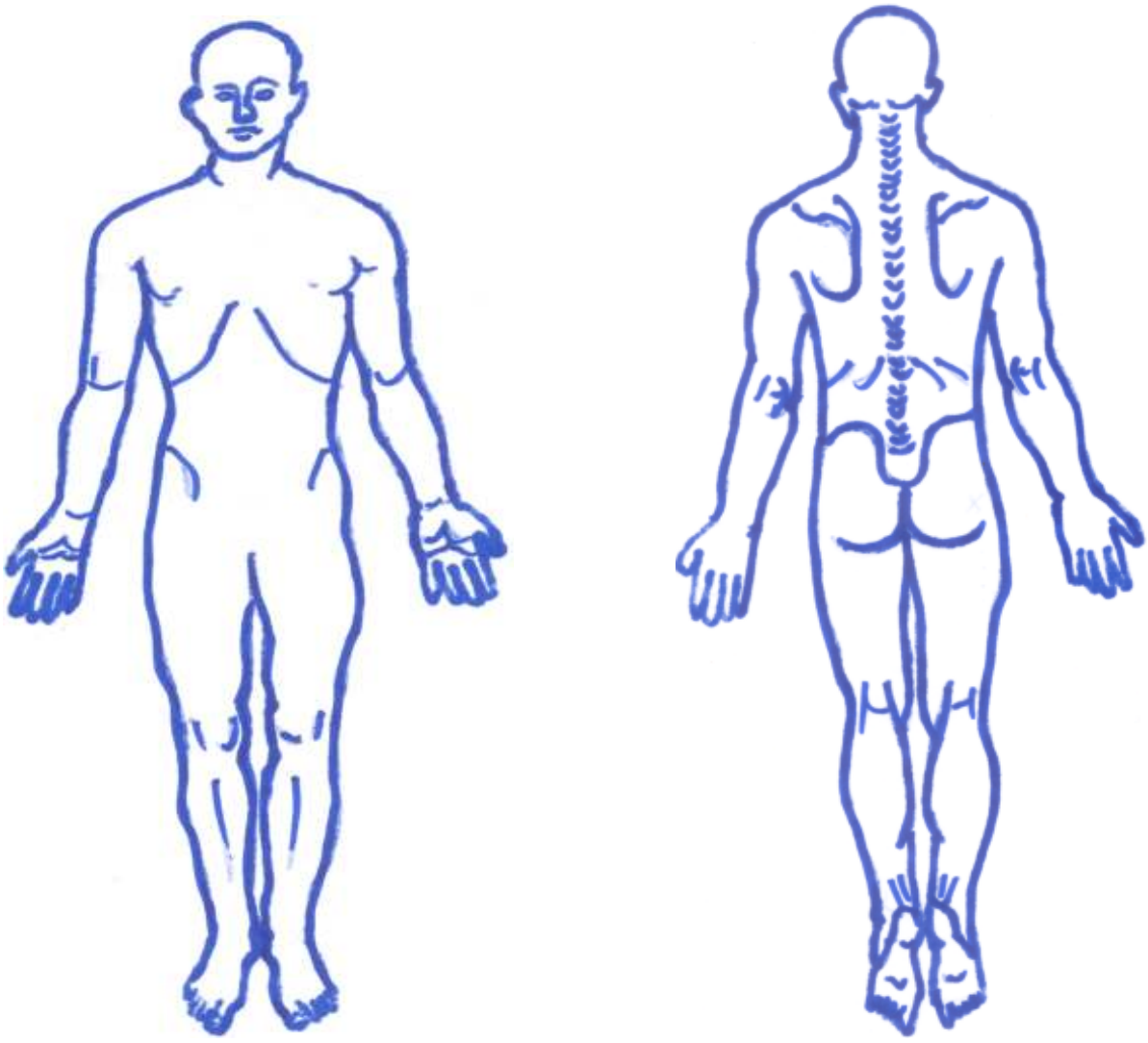
Please mark the following conditions that apply to you:

____contagious skin condition
____open sores or wounds
____recent accident or injury
____current fever or swollen glands
____cancer
____diabetes
____decreased/increased sensation
____back concerns
____pregnant
____Stress
____asthma
____joint disorder or artificial joint
____osteoporosis
____epilepsy
____heart condition
____high or low blood pressure
____circulatory disorder
____varicose veins
____allergies – perfumes, skin irritants
____Frequent headaches

IF YOU ANSWERD “YES” TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW:

Please list any other medical concerns/issues/diagnoses of which we should be aware:

Please circle any specific areas below you would like the massage therapist to concentrate on during your session:



What are your MAIN GOALS for today's session?

What are your LONG TERM GOALS?

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature: _____ Date: _____

Thank you for visiting Amb Day Spa!

PRACTITIONER'S NOTES: