

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Occupation: _____

Emergency Contact Person: _____ Phone: _____

Are you currently under a physician's care for an acute or chronic illness? Y _____ N _____

If yes please explain: _____

If yes, who is your health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? Y _____ N _____

If yes, please explain: _____

Have you received a massage before? Y _____ N _____ If yes, when: _____

How did you hear about me? _____

What are your goals for this session: _____

Please list areas of tension, stress and/or pain you wish to have addressed: _____

Are you pregnant? Y _____ N _____ If yes, how far along? _____

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions

☐ Abdominal /digestive
☐ Diabetes
☐ Fatigue
☐ Headaches, migraine
☐ Hearing problems
☐ Hernia
☐ High blood pressure
☐ Jaw pain/TMJ pain
☐ Low blood pressure
☐ Musculo/bone injuries
☐ Constipation/diarrhea

☐ Depression
☐ Rash/fungus
☐ Sinus problems
☐ Sleep difficulties
☐ Spinal disorders
☐ Sprain/strain
☐ Tension/stress
☐ Vision problems
☐ Varicose veins
☐ other problems
☐ Numbness/tingling

☐ Pregnancy problems
☐ Allergies
☐ Anxiety
☐ Arthritis/tendonitis
☐ Asthma or lung cond.
☐ Athletes foot
☐ Blood clots
☐ Chronic pain
☐ Circulatory/heart
☐ Musculo/joint pain
☐ Cancer

Elaborate on noted areas above:

Please list any recent injuries or surgeries within the past 5 years:

Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

New Spa Client Intake Form Template

Susan G. Salvo



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