Cristabel SPA & WELLNESS
BE KIND. BE NATURAL. BE YOU.

# Massage Client Intake and Consent Form

Name _____ Date of Birth _____ ❑ Male ❑Female

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Occupation _____

How did you hear about us? _____ Referred By _____

In Case of Emergency, Contact _____ Phone _____ Relationship _____

Are you currently under the care of a Physician? ❑ Yes ❑ No If yes, reason_____

## Massage Information

**Please take a moment to carefully answer the following questions. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to services being provided**.

Have you had a professional massage before? ❑ Yes ❑ No
If yes, how frequently do you get a massage? _____

_____

If yes, do you have a style or pressure preference?
❑ light ❑ medium ❑ firm pressure
❑ Other _____

What type of massage are you seeking today?
❑ Relaxation/Swedish ❑ Deep Tissue ❑ Aromatherapy
❑ Pregnancy ❑ Hot Stones
❑ Other _____

What do you hope to accomplish from today's massage?

_____

Are you sensitive to fragrances or perfumes? ❑ Yes ❑ No

Do you have any known allergic reactions? ❑ Yes ❑ No
If yes, please describe _____

Do you have sensitive skin? ❑ Yes ❑ No

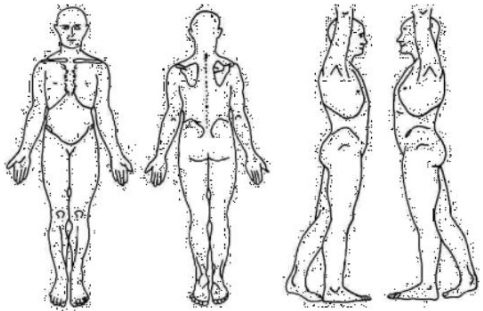
Do you exercise regularly? ❑ Yes ❑ No

What are your common areas of pain or tension? _____

_____

_____

Are you aware of any tension holding spots in your body? ❑ Yes ❑ No
If yes, Circle any specific areas you would like the massage therapist to concentrate on during the session:



## Medical History

Are you currently experiencing any of the following conditions?
❑ Flu/Cold ❑ Inflammation ❑ Fever
❑ Infection ❑ Contagious Disease

Do you suffer from chronic or persistent pain/discomfort?
❑ Yes ❑ No If so, for how long? _____

Do you know what causes/caused it or when the symptoms seem to get worse or better? _____

Do you see a chiropractor? ❑ Yes ❑ No
If so, how often? _____

Are you currently under medical care? ❑ Yes ❑ No

Are you currently taking any prescription medication?
❑ Yes ❑ No If so, name meds and reason _____

_____

_____

_____

Please indicate any condition that you have had or currently have:

| | |
|---|---|
| ❑ Headaches / Migraines | ❑ Varicose Veins |
| ❑ Allergies / Sensitivity | ❑ Currently Pregnant |
| ❑ Arthritis / Tendonitis | ❑ Blood Clots |
| ❑ Bruise Easily | ❑ Epilepsy / Seizures |
| ❑ Cancer / Tumors | ❑ Neck / Back Injuries |
| ❑ TMJ Problems | ❑ Diabetes |
| ❑ Abnormal Skin Condition | ❑ Paralysis |
| ❑ Heart / Circulation Problems | ❑ Fibromyalgia |
| ❑ Joint Replacement / Surgery | ❑ Numbness |
| ❑ High / Low Blood Pressure | ❑ Sprains, Strains |
| ❑ Major Accident | ❑ Recent Injuries |

❑ Lack Of -or- Reduced Feeling / Sensation _____

Explain any condition you have marked above: _____

_____

_____

_____

Are there any other health concerns you wish to discuss today?
❑ Yes ❑ No If yes, please describe: _____

_____

_____

## Lifestyle Habits

How many times per week do you exercise? □ Never □ 1-2 □ 3-4 □ 5+
What do your daily work habits include? (i.e. sitting, standing, light labor, heavy labor, computer work):
_____
How would you rate your eating habits? □ Poor □ Fair □ Good □ Excellent
How many glasses of water do you drink per day? □ 0 □ 1-3 □ 4-6 □ 8-10 □ 11+
How often do you eat fresh fruits and vegetables per day? _____
On a daily basis, what do you eat:
For breakfast? _____
For lunch? _____
For dinner?_____
For snacks? _____
What vitamins and nutritional supplements do you currently take?
_____
Do you smoke? □ Yes □ No How much per day? _____
How often do you consume alcohol on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
How many hours of sleep do you get per day/night? _____
How many bowel movements do you have per day? □ 0 (how many per week: _____) □ 1 □ 2+

# Client Consent for Treatment

By signing this consent, I agree that I have stated all conditions that I am aware of and the information is true and accurate to the best of my knowledge. I will inform my massage therapist if anything changes in my status. I understand that the massage/bodywork I receive is for the purpose of stress reduction and relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level.

I understand that a massage therapist cannot diagnosis illness, disease, or any physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal or skeletal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and I understand that it is my responsibility to consult a physician for any ailments I may have.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and release from any liability the massage therapist, as well as any officers, directors, or employees of Cristabel Spa & Wellness for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive. Sexual advances and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated, resulting in immediate termination of the session and I will be liable for payment of the scheduled treatment.

I agree to abide by a 48 hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 48 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, she/he will fulfill the scheduled massage length.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

Print Name: _____
Signature: _____
Date: _____