LOTUS THAI SPA

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Therapeutic Massage - Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City, Postcode _____

Email (*optional*) _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

Physician _____ Phone _____

Massage Information

How did you hear about us? _____

Have you ever had a professional massage before? □ yes □ no

If yes, how often to you receive massage therapy? _____

If yes, do you have a style or pressure preference? □ yes □ no

Specify : □ light pressure □ medium pressure □ deep pressure

□ trigger point therapy □ energywork

□ Other _____

What Type of massage are you seeking today?

□ Relaxation □ Deep Tissue/Therapeutic □ Pregnancy

□ Senior □ Integrated Bodywork (*functional*)

□ Other _____

Are you sensitive to fragrances or perfumes? □ yes □ no

Do you have sensitive skin? □ yes □ no

Do you wear contact lenses? □ yes □ no

Do you exercise regularly? □ yes □ no

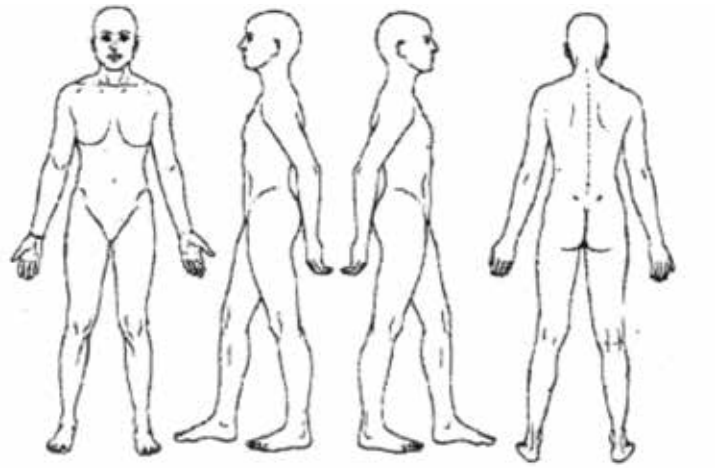
If so, what type(s)? _____

What are your common areas of pain or tension?

_____

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you suffer from chronic or persistent pain/discomfort?

_____

If so, for how long? _____

Do you know what caused it or when then 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? If so, for what? _____

_____

_____

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

□ headaches, migraines
□ allergies, sensitivity
□ arthritis, tendonitis
□ cancer, tumors
□ TMJ problems
□ abnormal skin condition
□ heart/circulation problems
□ joint replacement / surgery
□ high / low blood pressure
□ major accident
□ varicose veins
□ pregnancy
□ blood clots
□ neck / back injuries
□ diabetes
□ paralysis
□ fibromyalgia
□ numbness
□ sprains, strains
□ recent injuries
□ lack of or reduced feeling / sensation _____

Explain any conditions that you have marked above:

_____

_____

_____