MASSAGE THERAPY INTAKE FORM **OASIS Spa & Wellness LLC**

MM30248

CLIENT INFORMATION

Name _____ Email _____
Address _____ City _____ State _____ Zip _____
Phones: Home _____ Cell _____ Business _____
Birthdate _____/_____/_____ Occupation_____
Recreational Activities _____ Hobbies _____
Referred By _____

CLIENT CONDITION

Currently under a physician's care? _____ For what condition? _____
Doctor's name _____
Current medications _____
Location of current pain _____ How long have you had this pain? _____
How often? _____

Type of Pain	[ ] sharp	[ ] dull	[ ] throbbing	[ ] numbness	[ ] aching	[ ] shooting
	[ ] burning	[ ] tingling	[ ] cramping	[ ] stiffness	[ ] swelling	[ ] other_____
Interferes w/	[ ] work	[ ] sleep	[ ] recreation	[ ] daily routine	[ ] other _____	
Painful moves	[ ] sitting	[ ] standing	[ ] walking	[ ] bending	[ ] lying down	[ ] other_____

MASSAGE HISTORY

Have you ever received a professional massage? [ ] No [ ] Yes - Frequency: [ ] Weekly [ ] Monthly [ ] Yearly
What results do you want from your massage session(s)? _____

HEALTH HISTORY

Please check all conditions that apply:

[ ] Allergies _____	[ ] Arthritis_____	[ ] Blood Clots _____
[ ] Bursitis _____	[ ] Cancer, Tumors _____	[ ] Cardiovascular_____
[ ] Diabetes _____	[ ] Digestive_____	[ ] Disk Problems _____
[ ] Headaches_____	[ ] High Blood Pressure_____	[ ] Infectious Disease _____
[ ] Infection _____	[ ] Liver/Kidney_____	[ ] Neurological_____
[ ] Pinched Nerve_____	[ ] Pregnancy _____	[ ] Respiratory_____
[ ] Rods/Plates/Implants _____	[ ] Skin Disorder _____	[ ] Tendonitis_____
[ ] TMJ Syndrome_____	[ ] Tingling, Numbness _____	[ ] Varicose Veins_____

List any medical conditions, surgeries, accidents or injuries not specified above:_____

_____

AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or OASIS Spa & Wellness LLC responsible for any errors or omissions that I have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my therapist of any changes in my health status. I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. I give my consent to receive massage therapy from my duly licensed therapist and release them and OASIS Spa & Wellness LLC from any liability.

Client Signature_____ Date_____