TRUE ESSENCE
TRANQUILITY

NEW CLIENT INTAKE FORM

Name: ______________________ Birthdate: ___ / ___ / ___

Home #: __________ Cell #: __________ Work #: __________

Address: ______________________

City: __________ State: __________ Zip: __________

Email: ______________________

Emergency Contact #: __________ Name/Relation to you: __________

Occupation: ______________________

How do you prefer to be contacted? ☐ Cell ☐ Home ☐ Work ☐ Email ☐ Facebook

Who referred you / how did you hear about us? We would like to thank them! __________

May we contact your place of business for promotional opportunities / chair massages? ☐ Yes If yes, who is your employer?

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge….

Have you had professional massage / Reiki / shiatsu / skincare before? ☐ Yes ☐ No If yes, how often do you receive?

Do you have any difficulty lying on your front, back or side? ☐ Yes ☐ No If yes, please explain:

Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No If yes, please explain:

Do you have sensitive skin? ☐ Yes ☐ No Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid? ☐ None

Do you sit for long hours driving, or sitting at a workstation or computer? ☐ Yes ☐ No If yes, please describe:

Do you perform repetitive movement in your work, sports or hobby? ☐ Yes ☐ No If yes, please describe:

Do you experience stress in your work, family or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think it has effected your health? ☐ Muscle tension ☐ Anxiety ☐ Insomnia ☐ Irritability ☐ Other

Is there a particular area of the body where you are experiencing tension, stiffness, pain, skin irritation or other discomfort? ☐ Yes ☐ No
If yes, please identify:

What goals do you have in mind for this session? ____

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MEDICAL HISTORY

In order to plan a session that is safe and effective, we need some general information about your medical history.

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list: ______________________

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Please check any condition listed below that applies to you:

☐ contagious skin condition
☐ open sores or wounds
☐ easy bruising
☐ recent accident or injury
☐ recent fracture
☐ recent surgery
☐ artificial joint
☐ sprains / strains
☐ current fever
☐ swollen glands
☐ pregnancy; if yes, how many months? ____________ months

☐ headaches / migraines
☐ allergies / sensitivity
☐ heart condition
☐ high or low blood pressure
☐ circulatory disorder
☐ varicose veins
☐ atherosclerosis
☐ phlebitis
☐ deep vein thrombosis / blood clots
☐ joint disorder / rheumatoid arthritis

☐ osteoarthritis / tendonitis
☐ osteoporosis
☐ epilepsy
☐ cancer
☐ diabetes
☐ decreased sensation
☐ back / neck problems
☐ fibromyalgia
☐ TMJ
☐ carpal tunnel syndrome
☐ tennis elbow

Please explain any condition that you have marked above. Include any information that would be useful to know in planning a safe and effective massage for you:

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Draping will be used during the session. Only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent of legal guardian during the entire session. Informed, written consent must be provided by parent or legal guardian for any client under the age of 17.

I, ____________________________________, understand that the therapy 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 may be adjusted to my level of comfort. I further understand that massage/Reiki/professional skincare 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/Reiki/therapists/estheticians 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 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 therapists' part should I fail to do so.

Signature of Client/Guardian: ____ Date: ____________________

Signature of Therapist ____ Date ____________________