

WELLNESS AESTHETICS

Massage Therapy Intake Form

Client Information:

Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Emergency Contact: _____

Referred By: _____

Medical History:

Please check all that apply:

- High Blood Pressure Diabetes Heart Condition
- Varicose Veins Recent Surgeries Joint Replacements
- Pregnant/Breastfeeding Allergies (list): _____
- Medications (list): _____

Do you experience:

- Chronic Pain Stress/Anxiety Limited Mobility
- Numbness/Tingling Recent Injury Headaches/Migraines

Preferred pressure: Light Medium Firm

Are there areas you'd like the therapist to avoid? _____

Cancellation Policy:

All appointments require 36 hours' notice for cancellation or rescheduling. Failure to do so may result in a fee. First missed appointment is forgiven, second missed appointment is subject to a charge. By signing below, you agree to this policy.

Photo Consent:

I give permission for my massage session photo to be used for marketing purposes.

I do not consent to photo use.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____