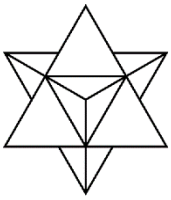
Soulstone Spa & Apothecary



Client Intake Form

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it. All information disclosed will be kept for session purposes only and in strict confidentiality.

Name_____ Birth Date_____

Address_____ Apt/Suite_____

City_____State_____Zip_____

Cell _____ Home_____

Occupation_____E-Mail_____

Emergency Contact_____Phone_____

How did you hear about Soulstone Spa & Apothecary? Internet ☐ Advertisement ☐

Friend ☐_____ Other☐ _____

Have you ever received Massage Therapy? Yes ☐ No ☐ Date of last massage: _____

Are there any areas you DISLIKE being massaged? (Ex: face, scalp, feet, abdomen, etc.)

_____

Do you have difficulty getting into or staying in any of the following positions?

Supine (Face up) ☐ Prone (Face down) ☐ Side lying on Right ☐ Side lying on Left ☐

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort. ****

Medical Health History Information

Please list medications. _____

_____

Have you had any major surgeries and when? _____

_____

Do you have a pacemaker or implanted defibrillator? (Please provide details) _____

_____

Have you (ever) been diagnosed with a deep vein thrombosis, pulmonary embolism, or have a history of blood clots? If so, please explain: _____

Please mark the correct box for any conditions that you currently have or have had in the past:		**Please indicate the primary reason(s) for your visit today:**
☐ Allergies	☐ HIV/AIDS	☐ Relaxation
☐ Bone/Joint Disease	☐ Jaw Pain/TMJ	☐ Pampering
☐ Bone/Joint Injury	☐ Lower Back/Hip Pain	☐ Stress Relief
☐ Hepatitis A, B, or C	☐ Muscle Spasms	☐ Therapeutic
☐ Cancer	☐ Numbness/Swelling	☐ Pain Management
☐ Depression	☐ Pacemaker	☐ Other: _____
☐ Diabetes	☐ Painful Feet/Swelling	
☐ Fibromyalgia	☐ Pregnant? # weeks? ____	
☐ Headaches/Migraines	☐ Stiffness	
☐ Head Injuries	☐ Tendonitis	
☐ Heart Condition	☐ Vertigo	
☐ High Blood Pressure	☐ Warts	
☐ Botox or filler injections		

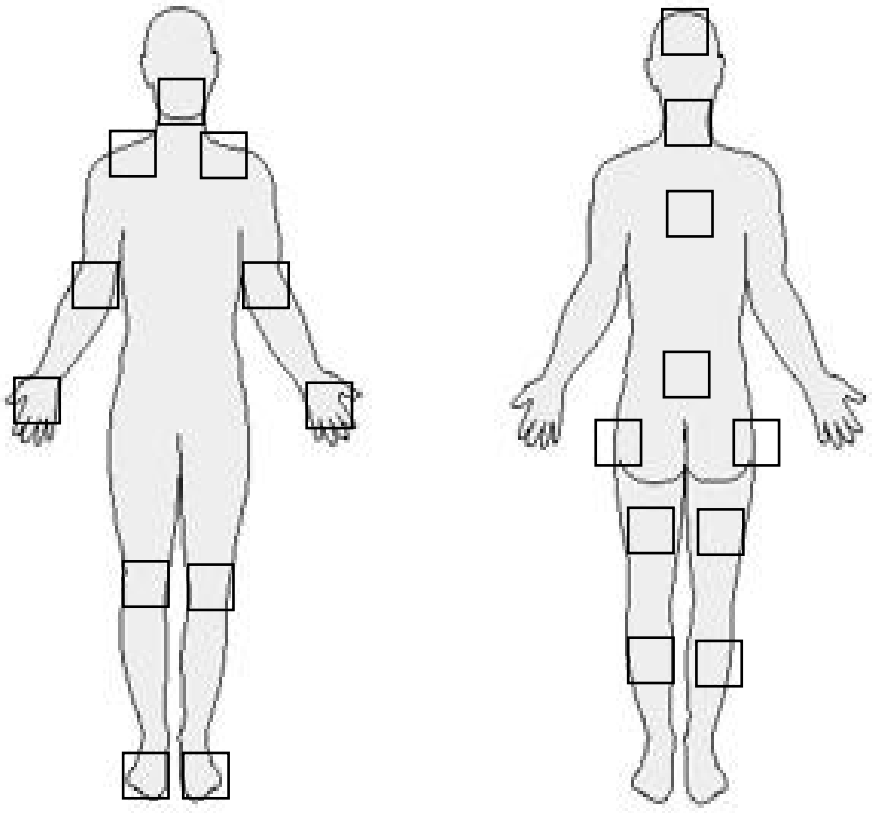
I understand that the services I receive are provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that massage/bodywork should not be a substitute for medical examination, diagnosis, or treatment.

Please indicate if signing for a child. Yes ☐ No ☐

Signature_____ Date_____

PLEASE COMPLETE DIAGRAM ON NEXT PAGE >

Please indicate all areas that you would like your therapist to focus on.



FOR THERAPIST USE:

OBJECTIVE

Muscle/Region	Right	Left
Paraspinals	□	□
Cervical	□	□
Thoracic	□	□
Lumbar	□	□
Sacral	□	□
SCM	□	□
Scalenes	□	□
Pectoralis	□	□
Suboccipital	□	□
Deltoids	□	□
Trapezius	□	□
Upper	□	□
Middle	□	□
Lower	□	□
Levator Scapula	□	□
Rhomboids	□	□
Rotator Cuff	□	□
Biceps	□	□
Triceps	□	□
Quad. Lumb.	□	□
Abdominals	□	□
Iliopsoas	□	□
Quadriceps	□	□
Hamstrings	□	□
Gluteus	□	□
Maximus	□	□
Medius	□	□
Minimus	□	□
TFL/IT Band	□	□
Adductors	□	□

Therapist Notes:

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_____

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