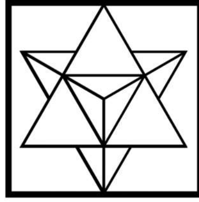
SOULSTONE SPA & APOTHECARY



Client Intake

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: ____________________

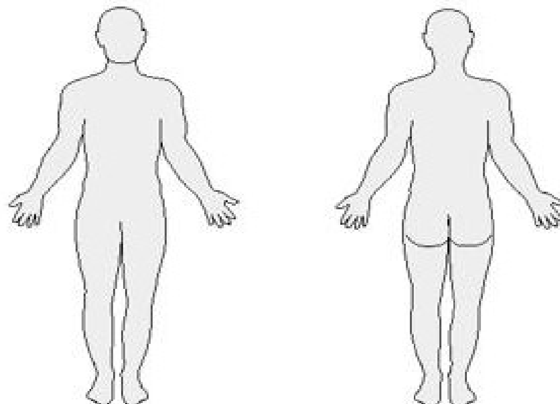
Are there any areas you DISLIKE being massaged? (Ex: face, scalp, feet, abdomen, etc.)

____

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 ☐

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



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(347) 766 – 1936
Info.Soulstone@gmail.com

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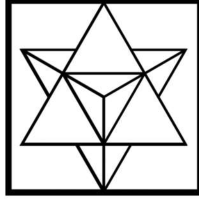

Client Intake - General Medical History

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 – ***See Oncology History form***	□ 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		

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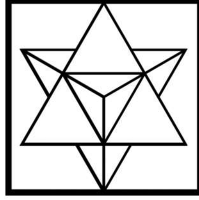

Client Intake - Oncology History

What is your cancer diagnosis?

____

____

Select and describe all cancer related treatments you are or have undergone. List all side effects as well.

□ Surgery

□ Lymph nodes removed? # ________

____

____

____

____

□ Chemotherapy

□ Ongoing? Date of last dose? ________

____

____

____

____

□ Radiation Therapy

□ Ongoing? Date of last dose? ________

____

____

____

____

□ Immunotherapy

____

____

____

____

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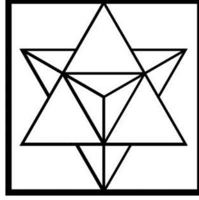

Client Intake - Oncology History

□ Hormone Therapy

□ Ongoing? Date of last dose? _________

____
____
____
____

Are you currently in remission? Yes □ No □

Has your doctor approved massage during your treatment? Yes □ No □

Please provide your oncologist's contact information.

Name: ____

Address: ____

Phone: ____

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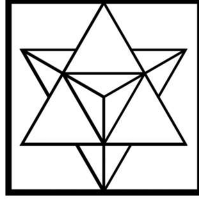

Client Intake

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. ***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.***

Please indicate if signing for a child. ***Parents / guardians must remain on premises while minor receives treatment.*** Yes □ No □

Signature____ Date_________________________

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Client Intake

Therapist Notes:

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