Massage Intake Form

Welcome to

Revival FLOAT SPA

Our goal is to deliver the best experience possible. To customize your experience and exceed your expectations please complete the questions below. For the following categories, please circle all that apply.

Name: _____

Email:_____

Cell Phone: _____

Mailing Address: _____

Zip Code_____ Date of Birth:_____

Occupation:_____ Referred by:_____

Preferred Method of Contact: Phone Email

Would you like Appointment Reminders sent to your Cell Phone? Yes or No

For Face

What are your concerns?

Dry Skin Dehydration Allergies Sinus Pressure

For Body

What are some of your concerns?

Muscle Tension Stress Discomfort Dry skin Cellulite Circulation
Sunburned Arthritis Soreness Numbness Poor Posture
Digestive issues

Desired Massage Pressure Light Firm Deep Tissue

For Hands & Feet

Age Spots Dry Skin Dry Cuticles Callous
Fragile/Brittle Nails Soreness Flat Feet Muscle Tension

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It is not advisable to engage in certain treatments where specific medical conditions exist.

Please review and check those conditions that have affected your health either recently or in the past. Place a check mark next to the conditions:

___ Arthritis
___ Diabetes
___ Blood clots
___ Broken/dislocated bones
___ Bruise Easily
___ Cancer
___ Chronic Pain
___ Constipation/Diarrhea
___ TMJ disorder
___ Vertigo
___ Depression, panic disorder, other psych condition
___ Diverticulitis
___ Headaches
___ Heart conditions
___ Back Problems
___ High/ Low blood Pressure
___ Spinal Injuries
___ Muscular Disorder
___ Chemical Dependency
___ Hepatitis (A, B, C, etc.)
___ Pregnancy
___ Skin Conditions
___ Scoliosis
___ Stroke
___ Seizures
___ Surgery
___Auto- Immune condition*

*AIDS, Lupus, Rheumatoid Arthritis, etc.

If any of the above needs to be detailed or if there is anything not listed, please explain:

_____

_____

Do you have any allergies? (Cosmetics, ingredients, food, iodine, medications, latex, etc.)

___No ___Yes (Please specify) _____

Are you currently undergoing chemotherapy or radiation therapy?

___No ___Yes (Please specify) _____

Are you currently taking any medications, herbs, or vitamins? (Internal or Topically)

__No ___Yes (Please specify) _____

Is there anything else we should know that may affect your treatment?

Other (Please specify) _____

Have you had or currently have any of the following within the last 5 days?

___Skin rash ___Cold/Flu/ ___Open cuts ___Injuries/bruises
___Anything contagious ___Severe pain:_____

Women only Do any of the following pertain to you currently?

___Hormonal Problems ___Pregnant ___Lactating
___Menopause ___Hormonal Birth Control ___Regular Menstruation

Are you currently wearing: ___ contact lenses ___ hearing aid ___ hairpiece

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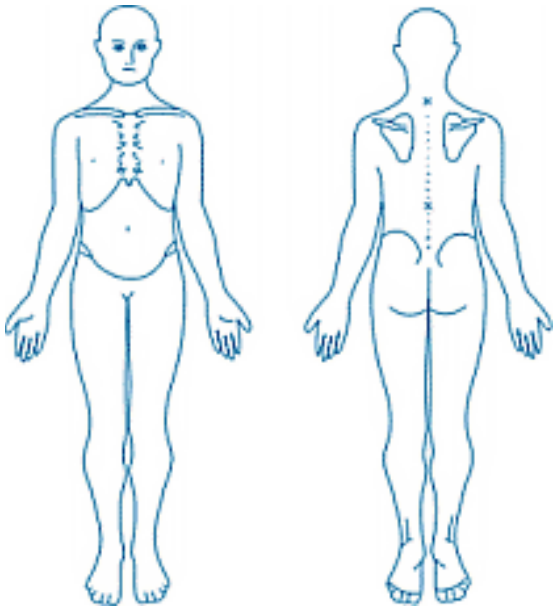
Please record any injuries, surgeries, or accidents and when they occurred (month/year)

_____

_____

_____

Please **circle** the areas in which you are feeling pain/discomfort, if any:



If you could improve one thing today what would it be?

_____

Please read the following and sign below:

1. I understand that although massage therapy is very therapeutic, relaxing, and is designed to address my concerns, it is not a substitute for medical examination, diagnosis and treatment. Never discontinue use of any medications or treatments without direct consent from your treating physician.

2. This is a therapeutic massage and any sexual remarks or advances will terminate the session immediately and I will be liable for full payment of the scheduled treatment.

3. All massage treatments should not be performed under certain medical conditions; therefore, I affirm that I have answered all questions pertaining to medical conditions and treatments thoroughly and truthfully.

4. I understand the 24-hour rescheduling policy and agree to the terms as mentioned on the company website. Rescheduling within 24 hours of your scheduled experience will incur the full-service fee.

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____