**Spa Massage Intake Form**

**Personal Details:**

* **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Massage History:**

* **Have you received professional massages before? [Yes/No]**
* **If yes, how frequently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Wellness:**

* **Do you have any chronic pain areas? [Yes/No] If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Are you pregnant? [Yes/No]**
* **Do you experience stress-related symptoms? [Yes/No]**

**Preferences Table:**

| **Preference** | **Select** | **Details** | **Notes** |
| --- | --- | --- | --- |
| **Pressure Level** | **☐ Light** | **☐ Medium ☐ Firm** |  |
| **Preferred Scents** | **☐ Lavender** | **☐ Peppermint ☐ Unscented** |  |
| **Room Temperature** | **☐ Warm** | **☐ Cool ☐ Neutral** |  |
| **Time Preference** | **☐ Morning** | **☐ Afternoon☐ Evening** |  |

**Acknowledgment:
☐ I understand the benefits and risks of massage therapy and consent to the session under these terms.**

**Signatures:
Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_
Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**