ZAIDA & SIERRA
Aesthetics

Date

Massage Intake Form

Personal Information

Name	DOB	AGE
Address		
Phone	Occupation	
Email		

Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____
Do you have any difficulty lying on your back, front, or sides? Yes No
If yes, please explain _____
Do you have any allergies to topical oils, lotions or ointments? Yes No
If yes, please list _____
Do you have sensitive skin? Yes No
Do you sit for long hours at a workstation, computer, or driving? Yes No
Do you perform any repetitive movements in your work, sports, or a hobby? Yes No
If yes, please explain _____
Please describe your daily stress level on a scale of 1 to 10: Low 1 2 3 4 5 6 7 8 9 10 High
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please explain _____
Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____
Are you currently under medical supervision? Yes No
If yes, please explain_____
Do you see a chiropractor? Yes No
If yes, how often? _____
Are you currently taking any medications? Yes No
If yes, please list _____
Please explain when your symptoms began and any aggravating factors:
_____
_____
_____
_____
_____
_____
_____

Medical Conditions

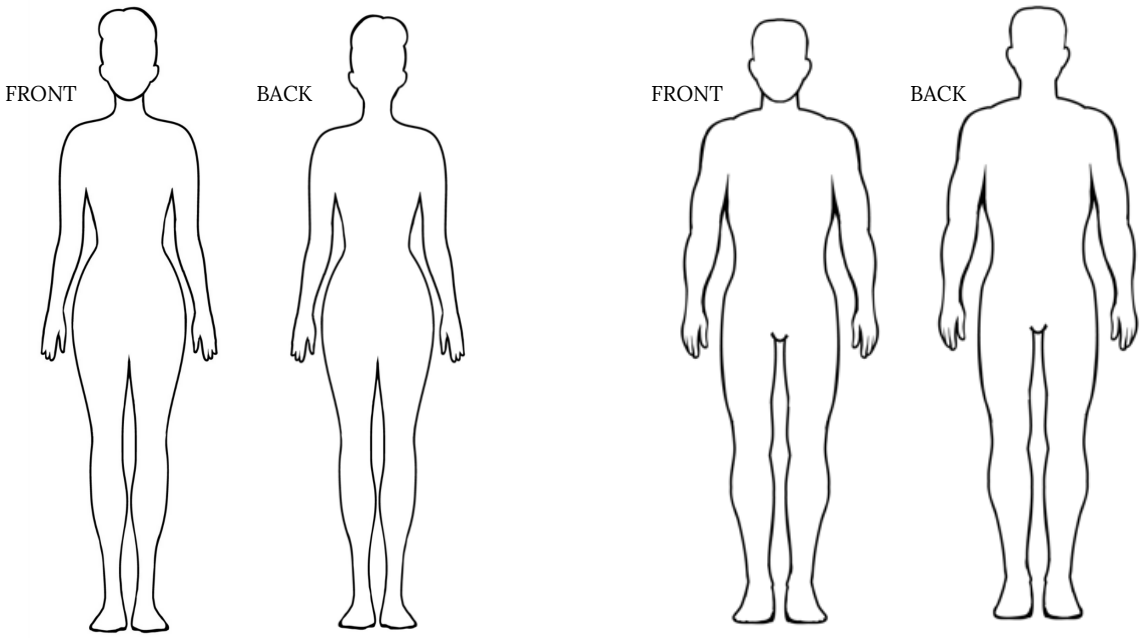
Medical Background: Check all that apply (past and present)

- ☐ Broken Bones/Fractures
- ☐ Cancer
- ☐ Contagious Skin Disease
- ☐ Transdermal Drug Delivery System
- ☐ Anticoagulants (Blood Thinners)
- ☐ Vericose Veins
- ☐ Deep Vein Thrombosis/ Blood Clots
- ☐ Tennis Elbow
- ☐ Epilepsy
- ☐ Cardiac/Vascular Problems
- ☐ Unhealed Wounds
- ☐ Swollen Glands
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Phlebitis
- ☐ Pregnancy
- ☐ Bleeding Disorder
- ☐ Recent Surgical Incision
- ☐ Sunburn
- ☐ Ulcerated Skin
- ☐ Infection
- ☐ Heart/Kidney/Liver Disease
- ☐ Diabetes
- ☐ Atherosclerosis
- ☐ Psoriasis, Eczema, Rosacea
- ☐ Headaches/Migraines
- ☐ Osteoporosis
- ☐ Joint Disorder(s)
- ☐ Dislocations
- ☐ Plastic/Bone Cement/ Metal Implants
- ☐ Carpal Tunnel Syndrome
- ☐ High/Low Blood Pressure

☐ Other Medical Condition _____

☐ Current Medications: _____

Please mark any area/s/ of discomfort



By signing below, you agree to the following:
I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I understand that massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature

Date

Date

Massage Consent

Precautions (Please initial each)

_____I agree that I am over the age of 18, am NOT under the influence of alcohol or drugs, am NOT pregnant or nursing and desire to receive massage therapy. The general nature of massage therapy has been explained to me.

_____I understand that massage treatments are not suitable for everyone and the risks include but are not limited to allergies to the massage lotions, oils and/or creams, breaks in the skin, bruising, soreness, tissue damage, swelling, redness, and pain during or after treatment. Massage therapy may aggravate some medical conditions.

_____I understand that the therapist is not a physician and does not diagnose illness or disease or any other medical or mental disorder. I further understand that massage therapy is not a substitute for medical examination however, the massage therapist must be fully informed of my existing medical conditions.

_____I agree that I completed the medical history form provided by my therapist and disclosed any and all conditions I have or have had previously. It is my responsibility to keep my medical history up to date and inform my therapist.

_____I understand and acknowledge that payments for the above services are non-refundable.

_____By my signature below, I certify that I have read and understand the contents of this consent form.

_____I further agree to provide Zsaesthetics 24 hour notice of a cancellation or change in appointment time, or I will forfeit a treatment off my package since treatments are by appointment only.

_____I understand that any intoxication (alcohol consumption) during a massage treatment is not permitted. If I attend a session intoxicated, I will be asked to leave and will be charged the full price for the treatment session.

_____I acknowledge that sexual innuendos, language, and/or behavior will not be tolerated.

_____I agree to inform the massage therapist immediately if I feel any physical or mental discomfort during the treatment so that they may adjust accordingly.

_____I agree to hold Zsaesthetics harmless from any injury or damages as a result of misinformation provided by me or unknown underlying conditions not disclosed.

Signature

Date