The Connecting Point

School of Massage & Spa Therapies

Massage Intake

Name:_____ Date:_____

Have you ever had a massage before? _____
What is your main goal for this massage? _____
_____
_____
Do you have any circulatory or respiratory problems? _____
Do you have any allergies? _____
Do you have any current physical discomfort?_____
_____
Have you had any surgeries, whiplash, broken bones, torn ligaments, etc.?_____
_____
Are you currently being treated by a medical professional? _____
_____
_____
Are you taking any medication? _____
Do you have any skin, blood, bone, or immune conditions? _____
_____
Are you pregnant? _____

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension and for increasing circulation, energy flow and overall well-being. I understand the massage therapist does not diagnose illness, disease or any other physical or mental condition. I also understand this massage is being performed by a student of massage therapy.

Client Signature:_____ Date:_____

Your feedback is very important to the students and instructors of this program. Please take a moment to provide feedback about your service. Anything you especially enjoyed or felt could have been improved on? Please use the back of this form for your response.
Thank you for your essential contribution to the growth of our students and program!