



MESSAGE INTAKE FORM CONFIDENTIAL INFORMATION

WELCOME! We would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name Date of birth

Address

City State Zip

Email Phone

Occupation How did you hear about us? **Thumbtack Facebook Google**
Other:
 (please circle) (please circle)

Have you ever received massage / skin therapy? Yes* No *If yes, how often?

Type(s) of massage or skin therapy experienced:

Are you currently taking any medications? Yes* No

*If yes, please list name and reason for medications

Are you currently seeing a healthcare professional? Yes* No

*If yes, please list reason/treatment

How often do you exercise? daily 1-3 times per week 3-5 times per week
 weekly bi-weekly sometimes rarely

Exercise routine, if any?

What is your skin type? Oily Dry Normal/Aging Acne Sensitive

IS IT OKAY IF WE USE doTERRA essential oils during your treatment? Yes No

Please review this list and **circle** those conditions that have affected you either recently or in the past.

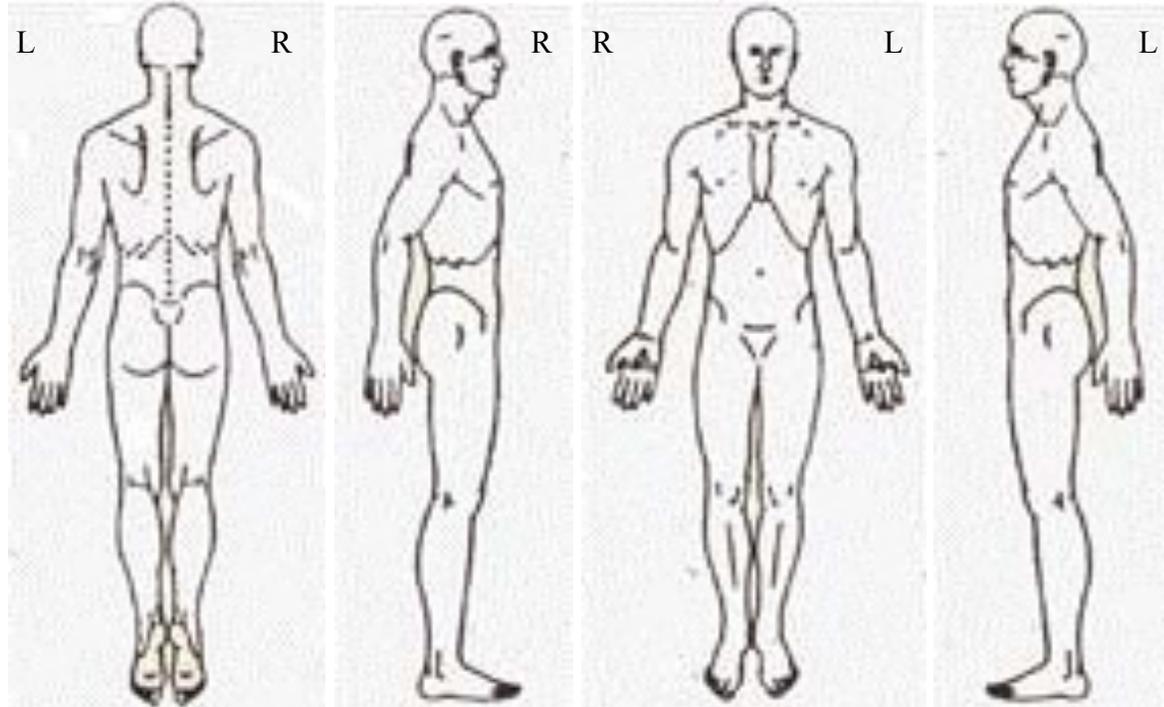
- | | | |
|-------------------------------|---|---|
| arthritis | varicose veins | *skin conditions |
| *diabetes | headaches | stroke |
| blood clots | heart conditions | *recent surgery |
| broken/dislocated | back problems | TMJ disorder/jaw pain |
| bones | high blood pressure | anemia |
| bruise easily | insomnia | herniated disks |
| cancer | muscle strain/sprain | *neurological problems |
| chronic pain | currently pregnant | wear contact lenses |
| constipation/diarrhea | scoliosis | wear hearing aids |
| auto-immune condition | seizures | open cuts |
| hepatitis (A, B, C,
other) | whiplash/recent car accident | depression/panic disorder/
other psych condition |
| aids | chemical dependency (alcohol,
drugs) | ulcers |
| open cuts | respiratory problems | muscle cramping |
| *allergies | fainting spells/dizziness | *injuries/ severe pain |
| cough/flu symptoms | | |

Please elaborate on the * selections (if circled on first page):.....

What are your **goals/expectations** for this therapy session?.....

Please mark and label the diagram with Stabbing pain, numbness, aches, burning, pins and needles or other problems.

X Stabbing Pain O Numbness /// Aches +++ Pins and Needles --- Burning



The following sometimes occurs during massage/facials. They are normal responses to relaxation. Trust your body to express what it needs to: * moving or changing position * sighing, yawning, change in breathing * stomach gurgling emotional feelings and/or expression * memories * energy shifts * falling asleep

Please read the following information and sign below:

1. I understand that although massage and skin therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage or facial and *any sexual remarks* or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage or facials should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. I consent to allow Urban Squeeze to email me information about our practice or other general information.

Signature: Date:

(If under 18 please have parent/guardian sign)