Touché
Medical Spa & Skin Care
Look & feel your best with experienced, leading-edge care & pampering.

Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I 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.

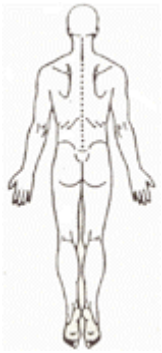
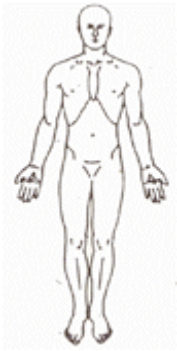
Name _____ Date of birth_____
Address_____
State_____ City_____ Home Phone_____
Work Phone_____ Occupation_____
Have you ever received massage therapy? _Yes _No
Type of massage experienced (swedish, shiatsu, deep tissue, etc.)
_____
Are you currently taking any medications? _ Yes _ No
If yes, please list name and reason for medications_____
_____
_____
Are you currently seeing a healthcare professional? _ Yes _ No
If yes, please list names and reason/treatment_____
_____
_____
Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

___arthritis
___blood clots
___bruise easily
___chronic pain
___auto-immune condition*
___skin conditions
___surgery
___depression, panic disorder, other psych condition
___headaches
___back problems
___insomnia
___pregnancy
___seizures
___diabetes
___broken/dislocated bones
___cancer
___constipation/diarrhea
___hepatitis (A, B, C, other)
___stroke
___TMJ disorder
___diverticulitis
___heart conditions
___high blood pressure
___muscle strain/sprain
___scoliosis
___whiplash
___chemical dependency
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

Do you have any of the following today:
_skin rash _cold/flu _open cuts _severe pain
_anything contagious _injuries/bruises

1905 Skibo Road • Fayetteville, NC 28314 (Across from Cross Creek Mall in the Rapha Plaza) (910) 864-4357 • Fax: (910) 221-0099

Do you have any allergies to:
_medications _foods (nuts, etc.)
_environmental allergens (dust, pollen, fragrances)
_reactions to skin care products
If any of the above are checked, please give details: _____
_____
Are you wearing: _contact lenses _ hearing aid _hairpiece
Please indicate with an (X), if any, the areas in which you are feeling discomfort:


What are your goals/expectations for this therapy session? _____
_____
The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
need to move or change position ✎ sighing, yawning, change in breathing
stomach gurgling ✎ emotional feelings and/or expression
movement of intestinal gas ✎ energy shifts ✎ falling asleep ✎ memories

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.
I understand that massage therapy is a therapeutic health aide.
I understand that if the massage therapist starts a session late, she/he will make it up to me at the end of my session if possible if time allows. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
I agree to give 24 hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24 hour notice to cancel or reschedule.
I understand if my insurance does not cover my massage I am responsible for the treatment in full.
Signature: _____ Date: _____