Solace THERAPEUTIC MASSAGE
SEEK COMFORT. FIND SOLACE.

Stone Massage · Integrated Positional Therapy (IPT) · Facial Reflexology

Confidential Intake Form

Name: _____ Date: _____

Phone: _____ _____Email: _____Occupation: _____

Age: _____ Have you experienced massage therapy or bodywork before? _____

What would you like to get out of your massage, IPT or reflexology session today? _____

_____

Primary Complaint: _____ Secondary: _____
_____ _____
_____ _____
_____ _____

How long have you experienced these symptoms and how would you rate them?

Primary: _____ Rating: _____ Secondary: _____ Rating: _____

Do you practice yoga? _____ Pilates? _____ Strength Training? _____

If you are being treated by a physician, please describe the condition(s) and symptom(s) being treated:

_____

_____

_____

Please list any pertinent information (including pregnancy), about allergies, surgeries, major illnesses, chronic conditions, injuries or psychiatric care and their respective date(s) of occurrence:

_____

_____

_____

_____

(over)

What is your daily fluid intake (# cups a day):

water _____ coffee _____ tea _____ alcohol _____ soda _____ other _____

How many hours do you work on a computer/at a desk daily? _____

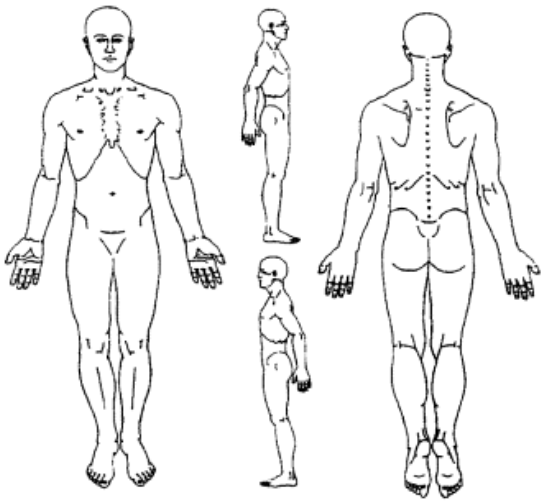
Frequent body positions, movements or activities that increase or cause pain (circle all that apply):

Walking	Running	Computer use	Reaching overhead
Walking up/down stairs	Kneeling	Driving	Squatting
Rising from a chair	Bending over	Turning head	Standing
Sleeping	Squeezing	Pushing	Lifting
Grabbing			

Are you currently experiencing a skin rash, open cuts, cold/flu or anything contagious? _____

Do you have sensitivities or allergies to nut oils or wheat germ, smoke (burning sage or incense), skin care products or essential oils? _____

Please indicate with an X any areas in which you are feeling discomfort:



Please read the following information and sign below.

1. This is a therapeutic massage and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled treatment.
2. Being that massage should NOT be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
3. I agree to communicate any discomfort during the session, including temperatures, weight and placement of stones as well as the pressure of the practitioner's massage strokes.
4. I agree to hold harmless the practitioner and the facility for any adverse reaction I may experience as a result of this massage.

Signature _____ Date _____