Park Hills Spa 1200 W. Polk Ave, Charleston IL 217.345.1010

New Client Intake

Name: Phone:

DOB: Address:

City: State/Zip:

Occupation: Emergency Contact:

Have you experienced a professional massage? □ Yes □ No --- Last Received:

Regular physical activities:

Other treatments you are currently receiving:
(Chiropractic/Acupuncture/Physical Therapy)

Areas of your body you would
prefer NOT be massaged:

Check any/all that apply to your present health:

□ headaches
□ dizziness
□ sinus problems
□ jaw pain/teeth grinding
□ high stress
□ difficulty sleeping
Location: ____________________

□ chronic pain
□ muscle/joint pain
□ numbness/tingling
□ scoliosis
□ arthritis
□ pregnant
How many weeks: _____________

□ limited range of motion
□ blood clots
□ high/low blood pressure
□ cancer/tumors
□ infectious disease
□ allergies: ____________________
____

Current medications/vitamins/herbs:

Previous major injuries/surgeries with approximate dates:

I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Massage therapy is not a substitute for medical treatment or medications, and it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I have informed the massage therapist of all my known physical/medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted. I acknowledge that with any treatment there can be risks and I assume those risks. Clients under the age of 18 must have written consent from a parent/guardian.

Client Signature: Date:
(Parent/Guardian if under 18 years old)