

# Serenity Day Spa

## MASSAGE INTAKE

Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Are you taking any medications? If so, please list:**

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**Are you currently pregnant? If so, how far along?**

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Please Indicate if any of the following apply to you:

**(Circle all that apply)**

Cancer / Headaches/ Migraines / Arthritis / Diabetes / High or Low Blood Pressure/  
Neuropathy/ Stroke/ Heart Attack/ Numbness/ Fibromyalgia/ Kidney Dysfunction/  
Blood Clots / Sprains or Strains

**Please Explain any of the above conditions:**

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**Have you ever had a professional massage before?**

YES/ NO

**What type of massage are you seeking?**

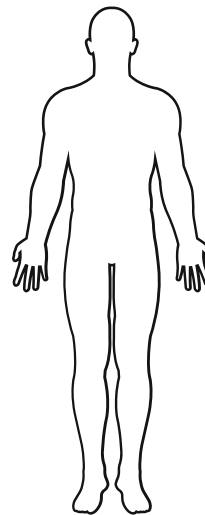
Relaxation/ Deep Tissue

**What pressure do you prefer?**

Light/ Medium/ Deep

**Do you have any allergies or sensitivities?**

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**Please Circle Any  
Areas of  
Discomfort**

**Client Signature:** \_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_