LAKE NORMAN SALT SPA

Client Intake Form

DATE: _____

Name: _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Birthdate: _____ **Occupation:** _____

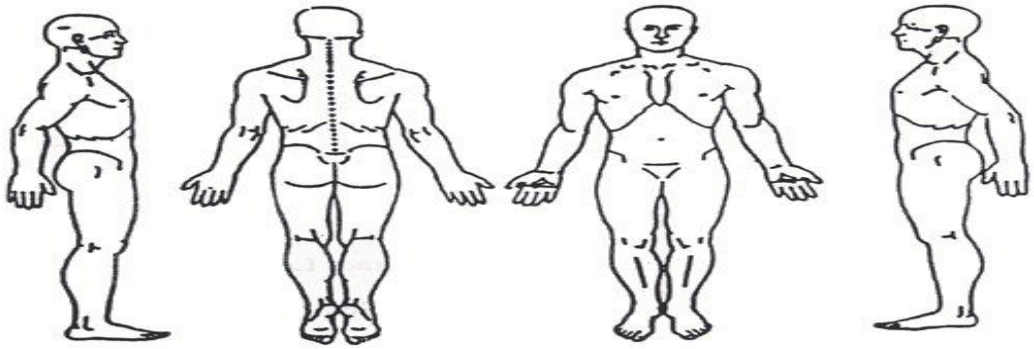
Emergency Contact: _____ **Emergency Phone:** _____

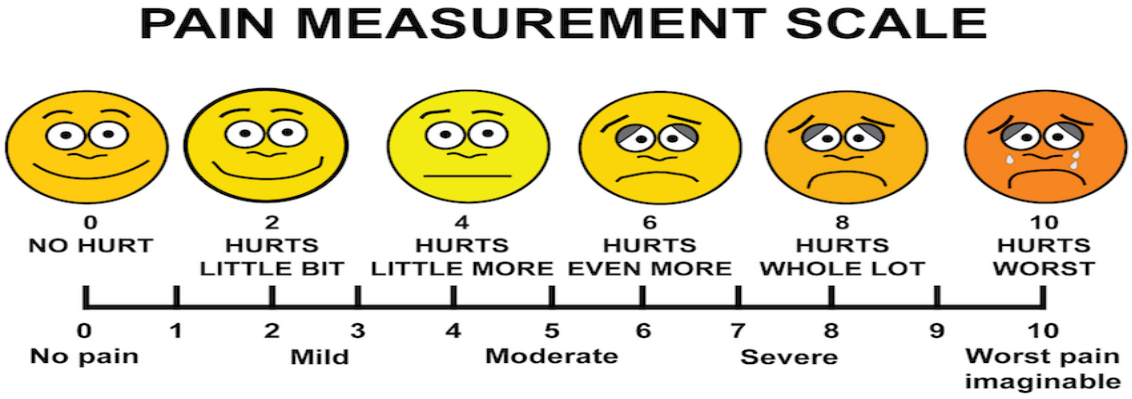
How do you wish to receive appointment **confirmations**? Phone / Text / Email

List all types of **exercise and hobbies**:

Do you have previous massage experience? Yes / No

What is the purpose for your visit today?





Do you currently have ANY of the following medical conditions?

Blood Clot, Brain / Nervous System disorder, Cancer, Contagious condition, Edema (swelling), Fever, Heart Failure or dysfunction, Implanted Device, Infection, Kidney Failure or dysfunction, Liver Failure or dysfunction, Lymphedema, Neuropathy, open or sutured wounds

Surgeries - Please list all surgeries:

Medical Conditions - please list all medical conditions you are under a doctors care for, past & present:

Medications - please list all medications you are currently prescribed and what they have been prescribed for:

Allergies - please list all allergies:

History of trauma - please list all accidents, injuries; skin, bone, muscle, organ, etc:

Is there anything I should know to ensure your **comfort**?

Contact lenses, smell or skin sensitivities, hearing, or movement limitations, etc

All information on this intake form is accurate and completed to the best of my ability, any updates or changes to this information will be reported to the therapist immediately. I understand that there shall be no liability on the therapists part should I fail to do so.

Client Signature: _____

If under the **age of 17**:

Signature of parent or legal guardian: _____