Massage Intake Form

Name_____Phone:_____Email:_____

Have you ever had a massage before? Yes / No

What type of massage have you had? _____

Do you have any allergies? Yes / No

What kind of allergies (food, medicine, seasonal) _____

Are you currently under a physicians care? (Please explain)_____

_____

Are you currently taking any medications? Please list _____

_____

_____

Do you exercise? How often and what type? _____

_____

How many caffeinated beverages do you drink per day? _____

How much water do you consume per day? _____

Do you have any history of back problems?_____

Do you have any history of joint pain or arthritis?_____

Are you pregnant? Yes / No

What kind of pressure do you prefer? Light / Moderate / Deep

How did you hear about O'Leigh Cosmetic Center & MedSpa?
_____

_____