

Mellow Massage Client Intake Form

Please take a moment to complete the following so that we may serve you in the most beneficial way.

Last Name	_____	Date	_____
First Name	_____	Email Address	_____
Street Address	_____	Home Phone	_____
City	_____	Mobile Phone	_____
State	_____	Date of Birth	_____
Zip	_____	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation	_____	How did you hear about us?	

Yelp Google
 Radio Print Ad
 Referral (Please list name of referring client to enter them into a monthly drawing for a complimentary massage!) _____
 Other (please specify) _____
 Would you like to learn more about our discount membership program and massage series options?

In Case of Emergency, please Notify:

Name _____
Phone _____
Relationship _____

Therapist Preference: Male Female No Preference

Have you ever received a professional massage? Yes No

If yes, what were your likes / dislikes from previous massage? _____

Are you experiencing physical pains? If yes, please explain. _____

Please specify the area(s) of your body that you would like your massage therapist to focus on.

Are you currently seeing a Medical Doctor? If yes, please explain _____

Current medication including TMIbuprofen, TMAspirin, etc. _____

Please check all of the following conditions you have recently experienced:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnancy (_____ weeks) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Skin Sensitivity |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure Disorders | <input type="checkbox"/> Skin Conditions/Warts |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Cold Hands and/or Feet | <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> PMS | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Other (Please Explain) | | |

Please list all surgeries within the past 5 years. _____

* Please remember to sign the Client Consent form on the next page



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Client Consent Form

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. **I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.** I am aware that the massage therapist is not an employee of Mellow Ltd. but is an independent contractor; therefore, Mellow does not warrant the performance of his/her services. I also understand that the massage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Client Printed Name _____

Client Signature _____

Date _____



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