Head to Heal Therapy and Spa Client Intake Information

Name:____ Date:__________

Address:______________________ City:__________ State:_____ Zip:________

Phone; _____________ Cell;______________ Date of Birth; ______________

Occupation:________________ Email:_______________________________

Emergency Contact:__________________________ Phone:________________

Have you ever received a professional massage? Yes No

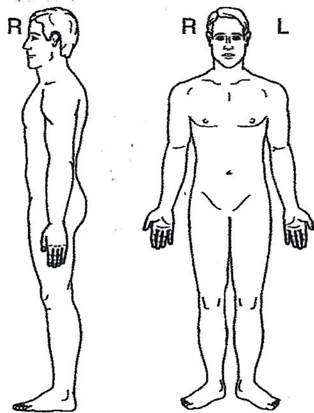
Are you currently seeing a medical professional? Yes No

Are you allergic to any lotions, oils, or food ingredients? Yes No

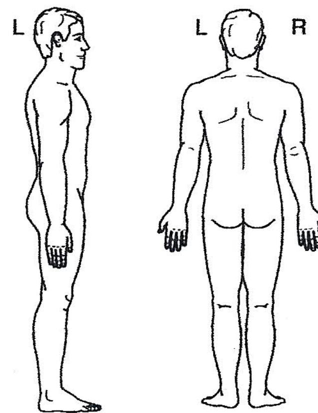
Are you taking any medications, aspirin, ibuprofen, herbs or supplements? Yes No

Accidents / Surgeries ? Yes No

Pain Scale Today: 1 2 3 4 5 6 7 8 9 10 Stress Scale Today: 1 2 3 4 5 6 7 8 9 10



Please mark areas of pain or discomfort.



——headaches, migraines
——vision problems, contact lenses
——hearing problems, hearing aides
——injuries to face or head
——sinus problems
——dental bridges, braces
——T.M.J. jaw pain
——asthma or lung conditions
——constipation, diarrhea
——hernia
——digestive problems

——chronic pain
——muscle or joint pain
——numbness or tingling
——sprains or strains
——arthritis, tendinit6is, bursitis
——cancer, tumors
——spinal column disorder
——diabetes
——pregnancy
——heart, circulatory problems
——high / low blood pressure

——fatigue
——tension, stress
——depression
——sleep difficulties
——allergies, sensitivities
——rashes, open sores
——fungal infections
——blood clots
——varicose veins
——HIV/AIDS
——fibromyalgia

Client Signature ________________________ Therapist ________________________