

Hilton Head Dental Spa - Massage Intake Form

Name- _____ Today's Date _____

Mailing Address _____

Telephone _____ Email _____ Birthdate _____

How do you prefer to be contacted (please circle): phone call, email or text

Referred by _____ Is this your first massage? _____

Occupation _____ Are you claustrophobic? _____

Are you on currently on any medications? _____ If so, for what? _____

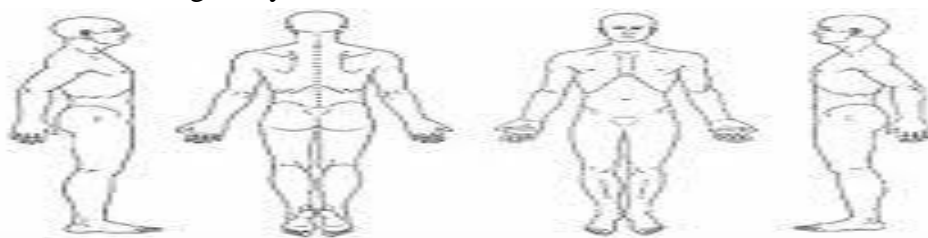
What is your preferred massage pressure? Light light/medium Medium medium/deep Deep

Have you had any of the following conditions in the past year?

- | | |
|----------------------------|-------------------------------|
| Sciatica | Muscle/Body aches _____ |
| Cancer- kind? _____ | Diabetes |
| Fibromyalgia | Headaches or Migraines |
| High or Low Blood Pressure | Lupus |
| Multiple Sclerosis | Parkinson's |
| Pregnant | Osteo or Rheumatoid Arthritis |
| Scoliosis | Stroke or Heart Attack |
| Varicose Veins | Broken bones or Car Accidents |

Are you ok with having the following areas worked on? face, hands, stomach, feet, or glutes (buttock muscles) Yes or NO

Main reason for coming today/area of concern? _____



Please read the following information and sign below: 1. I understand that although massage therapy can be very therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment. 2. This a therapeutic massage and any **sexual remarks/advances or inappropriate behavior** will terminate the session and I will be liable for payment of the scheduled treatment. 3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. Sign Name _____