

# A Beautiful Place Therapy Spa

## Client History/Intake Form

**Patient** \_\_\_\_\_ Sex Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Work# \_\_\_\_\_

Email \_\_\_\_\_

**Occupation** \_\_\_\_\_ Employer \_\_\_\_\_

Notify Emergency \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us \_\_\_\_\_

### **Please fill this portion, if you are filing with insurance. If not go to the next section.**

**Insurance:** Name of Company \_\_\_\_\_

Date of Incident \_\_\_\_\_ Group# \_\_\_\_\_

Claim/Policy# \_\_\_\_\_ Ref By \_\_\_\_\_

S.S.# \_\_\_\_\_ Adjuster \_\_\_\_\_

**Doctor** \_\_\_\_\_ **Attorney** \_\_\_\_\_

Phone# \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

**Employer** \_\_\_\_\_

Supervisor \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Was this case related to Work  Auto  or Other  Explain \_\_\_\_\_

How did it happen? \_\_\_\_\_

If it happened at work, was the employer notified? Yes  No

Has the insurance company been notified? Yes  No

Are you presently employed? Yes  No

If work related, are you working for same employer? Yes  No

Are you presently under a doctor's care? Yes  No

Have you ever been treated for the same condition? Yes  No

Were you admitted to the hospital? Yes  No  How long \_\_\_\_\_

What makes your condition worse? \_\_\_\_\_

### **Please answer the following questions.**

Have you had a professional massage before? \_\_\_\_\_ How often \_\_\_\_\_ Type \_\_\_\_\_

Do you wear Contacts? \_\_\_\_\_ Are you currently under a doctor's care? \_\_\_\_\_

Please explain \_\_\_\_\_

Surgery in past 4 years Yes  No  If yes, explain \_\_\_\_\_

Are you taking any prescription or over the counter medications? \_\_\_\_\_

---

Smoke Yes  No  Use alcohol Yes  No  Caffeine Yes  No

**Do you have a history of the following? Please check if "Yes".**

**Musculoskeletal:**

- Bone or joint disease
- Arthritis
- Sprains/Strains
- Low Back Pain
- Mid/Upper Back Pain
- Hip/Leg Pain
- Shoulder/Arm Pain
- Headaches
- Jaw Pain/Clicking/Popping
- Clenching or Grinding Teeth
- Spasms/Cramps
- Spinal Curvature
- Fibromyalgia
- Other \_\_\_\_\_

**Digestive:**

- Constipation
- Gas/Bloating
- Hiatal Hernia
- Other \_\_\_\_\_

**Respiratory/Circulatory**

- High/Low Blood Pressure
- Breathing Difficulties
- Varicose Veins
- Other Cardiovascular Problems
- Other \_\_\_\_\_

**Infectious Disease** \_\_\_\_\_

**Lymph Nodes Removal** \_\_\_\_\_ **If yes, Location** \_\_\_\_\_

**Spa Treatment Release:**

Please initial \_\_\_\_ you are agreeing to receive your scheduled treatment(s) today or future appointments.

- |                           |                         |         |
|---------------------------|-------------------------|---------|
| Application of Product(s) | Extractions (if needed) | Massage |
| Body Treatments           | Facial Equipment        |         |
| Body Wax                  | Microdermabrasion       |         |
| Chemical Peels            | Cleansing/Toning        |         |

**Our Promise to Our Client**

We will always treat you with respect, dignity, and the courtesy you deserve, not just as a client, but as an individual.

We will always make sure your appointment starts on time. We will never charge you for any service you do not receive.

We will always provide for your personal comfort and total body care through our adherence to exceptional standards.

**Neurological:**

- Herpes/Shingles
- Numbness/Tingling
- Chronic Pain
- Dizziness (any cause)
- Other \_\_\_\_\_

**Genitourinary:**

- Kidney Infections
- Kidney Stones
- Prostate Problems
- Other \_\_\_\_\_

**For Women Only:**

- Are you currently pregnant?
- Painful Menstruation
- Yeast Infections
- Breast Lumps/masses
- Other \_\_\_\_\_

**Other:**

- Allergies (any)
- Cancer/Tumors
- Sinus Problems
- Fatigue
- Difficulty Sleeping
- Diabetes
- Drug/Alcohol Addiction
- Other \_\_\_\_\_

**Skin problems** \_\_\_\_\_

**I understand the following:**

I understand that a block of time has been set aside for my treatment and I will arrive 5 minutes BEFORE my appointment and requires me to give no less than 24 hr notification for cancellation: failure to do so could result in a fee or prepayment for my next treatment.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical, chiropractic treatment or pharmaceuticals. It is in no way intended to be a substitute for professional health care. I have stated all medical conditions of which I am aware, and will update the therapist of any changes in my health status.

Signature\_\_\_\_\_ Date\_\_\_\_\_

Print Name