



Texas Client Intake Form

GENERAL INFORMATION			
Name:		Today's Date:	Occupation:
Address:		City:	State: Zip:
Phone: Cell:	Date of Birth (MM/DD/YY):	Email:	
Emergency Contact Name:		Phone:	How did you hear about us?
Preferred Method of Communication: Email <input type="checkbox"/> Phone <input type="checkbox"/>		Name Of Person Who Referred You:	
GENERAL HEALTH			
1. Rate your level of stress (1 = lowest, 5 = highest): 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>			
2. What physical activities do you enjoy?			
3. Do you wear contact lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO			
4. Allergic to Aspirin? <input type="checkbox"/> YES <input type="checkbox"/> NO or Skin Sensitivities/General Allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO Please be specific:			
5. Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how many cigarettes per day?			
6. Please list any accidents or surgeries in the last 12 months: <i>(If you have had surgery within the past 12 months please complete our Post Surgery Massage Consent Form)</i>			
7. Do you have: Metal Implants? <input type="checkbox"/> YES <input type="checkbox"/> NO A Pace Maker? <input type="checkbox"/> YES <input type="checkbox"/> NO Body Piercings? <input type="checkbox"/> YES <input type="checkbox"/> NO			
8. List the Medication(s)/Supplement(s) you are currently taking:			
9. Are you currently taking: <input type="checkbox"/> Antibiotic <input type="checkbox"/> Birth control <input type="checkbox"/> Hormone Replacement <input type="checkbox"/> Blood Thinners <input type="checkbox"/> N/A			
HEALTH HISTORY – Please check here if none apply <input type="checkbox"/>			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Irregular digestion	<input type="checkbox"/> Herpes Simplex Virus	<input type="checkbox"/> MRSA
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Eye Infection/Disorder	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Facial Warts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Keloid/Hypertrophic Scars	<input type="checkbox"/> Sun Allergy
<input type="checkbox"/> Allergy to Iodine or Shellfish			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Serious Sun burn or exposure			
<input type="checkbox"/> Hyper/Hypo Thyroid			
<input type="checkbox"/> Other:			
10. Have you ever been diagnosed with Cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If YES, please complete our Oncology Intake Form)</i>			
11. Are you pregnant/nursing or trying to become pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If pregnant how many weeks? <i>If YES, please complete our Prenatal Intake Form)</i>			
12. Any other medical condition or concerns we need to know about?			
MESSAGE THERAPY		GOAL FOR YOUR MESSAGE SESSION	
13. Have you had a professional massage before? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, when? How Often? Not often enough <input type="checkbox"/>		<input type="checkbox"/> Relaxation <input type="checkbox"/> Pain Relief <input type="checkbox"/> Stress Reduction	
14. Pressure? <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Firm <input type="checkbox"/> Not Sure		<input type="checkbox"/> Headache <input type="checkbox"/> Escape <input type="checkbox"/> Health/Wellness	
15. Is there any part of your body you would like to focus on today?		<input type="checkbox"/> Other	
		16. Is there any area of your body you do not want massaged?	
SKIN CARE			
17. Are you under the care of a dermatologist? <input type="checkbox"/> YES <input type="checkbox"/> NO			
18. Do you use any of the following? <input type="checkbox"/> Accutane <input type="checkbox"/> Retin A <input type="checkbox"/> Renova <input type="checkbox"/> Adapalene <input type="checkbox"/> Resorcinol <input type="checkbox"/> Scrub or Peel <input type="checkbox"/> N/A <input type="checkbox"/> Other prescription skin products, please be specific:			
19. Have you had any of the following? <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Microderm <input type="checkbox"/> Botox <input type="checkbox"/> Dermal Filler <input type="checkbox"/> Permanent Cosmetics <input type="checkbox"/> N/A <input type="checkbox"/> Other resurfacing treatments, please be specific: Any serious side effects? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20. Are you currently using any products that contain the following? <input type="checkbox"/> Glycolic Acid <input type="checkbox"/> Lactic Acid <input type="checkbox"/> Hydroxy Acid <input type="checkbox"/> Vitamin A <input type="checkbox"/> Vitamin C <input type="checkbox"/> N/A			
SKIN MAINTENANCE		Products Used – List Brand and Frequency of Use	
21. Skin Type: <input type="checkbox"/> Oily/Congested <input type="checkbox"/> Dry/Dehydrated <input type="checkbox"/> Sensitive/Redness <input type="checkbox"/> Acne <input type="checkbox"/> Sunburned		<input type="checkbox"/> Soap/Cleanser-	
22. Have you been tanning in the last 24 hours? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> SPF-	
23. In the last week have you had: <input type="checkbox"/> Waxing <input type="checkbox"/> Electrolysis		<input type="checkbox"/> Toner-	
24. What are your skin care goals?		<input type="checkbox"/> Exfoliator-	
		<input type="checkbox"/> Masque-	
		<input type="checkbox"/> Moisturizer-	



Texas Client Intake Form

It is my choice to receive spa treatments, including massage, skin care, hair removal or microdermabrasion. Because massage/bodywork, skin care and other spa treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, or answered all questions asked of me honestly. I will update Hand and Stone of any changes to my health status. I understand that Estheticians and Massage Therapists do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations or skeletal adjustments and that nothing said in the course of the session given should be construed as such. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that it is recommended I see a primary health care provider for that service. If I experience any pain or discomfort during the session, I will **immediately** inform the Massage Therapist or Esthetician so that the service may be adjusted to my level of comfort or discontinued. I could experience varying degrees of redness, burning, peeling, itching, etc., especially in the initial stages of a skin care program. I further understand that I am paying for a treatment and not a result and that there will be no returns, refunds or exchanges.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the missed appointment fee that applies. **Initial Here:** _____

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service. Further, I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. I hereby release the practitioners, Hand and Stone Massage and Facial Spa and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage, skin care (facials, peels), microdermabrasion or hair removal services. **The massage therapist will not perform breast massage on female clients without the written consent of the client prior to the massage session. Draping will be used during the massage session unless otherwise agreed to "in writing" by both client and therapist.**

I understand that I may disrobe to my comfort level. I acknowledge that it is my choice of a female or male massage therapist. I acknowledge receiving information about an "Attention button" feature (where applicable) attached to the massage table which when I activate will provide immediate assistance from the front desk. **Initial Here:** _____

Name Date

The information I have provided is accurate and true.

Client Signature: _____ Date: _____

MT/LE Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR: by my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer facial/massage techniques to my minor child or dependent as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____

Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services.

The massage therapist will not perform breast massage. Draping will be used during the massage session. If uncomfortable for any reason the client or therapist may ask to end the massage session, and the session will be ended.

CLIENT SIGNATURE: _____ DATE: _____

CONSENT TO TREATMENT OF MINOR: by my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer massage or bodywork techniques to my minor child or dependent as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____

To be completed by therapist:

Type of Massage Technique to be implemented and parts of the body to be massaged or avoided:

Licensed Massage Therapist

SIGNATURE: _____ DATE: _____

Hand and Stone Massage and Facial Spas are independently owned and operated franchise locations.