Salt MedSpa
Halotherapy

Breathe Well — Look Well
Feel Well

4905 Alabama Rd. NE Roswell GA 30075, 470-223-SALT (7258)

Welcome to Salt MedSpa!

Intake form: Massage

Please Note: **This a fragrance free establishment. Any perfumes, smoke, or scents may cause a severe reaction in others.**

Please fill out the form below.

Name: _____ Nickname: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email: _____

Preferred communication for confirming appointments and other special offers:

Phone Email Text Cell #: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Phone: _____

Allergies: _____

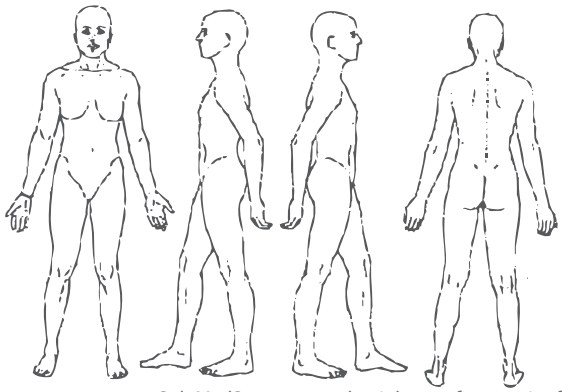
Occupation: _____ Primary Care Physician: _____

Referred by: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? ○ Yes ○ No
If yes, how often do you receive massage therapy? _____
Do you have any difficulty lying on your front, back or side? ○ Yes ○ No
If yes, please explain _____
Do you have any allergies to oils, lotions, or ointments? ○ Yes ○ No
If yes, please explain _____
Do you have sensitive skin? ○ Yes ○ No
Are you wearing; ○ contact lenses ○ dentures ○ a hearing aid?
Do you sit for long hours at a workstation, computer, or driving? ○ Yes ○ No
If yes, please describe _____
Do you perform any repetitive movement in your work, sports, or hobby? ○ Yes ○ No
If yes, please describe _____
Do you experience stress in your work, family, or other aspect of your life? ○ Yes ○ No
If yes, how do you think it has affected your health? _____
○ Muscle Tension ○ Anxiety ○ Insomnia ○ Irritability ○ Other _____
Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? ○ Yes ○ No
If yes, please explain _____

CIRCLE ANY SPECIFIC AREAS YOU WOULD LIKE THE MASSAGE THERAPIST TO CONCENTRATE ON DURING THE SESSION:



Salt MedSpa reserves the right to refuse service for any reason.

Please note: Lockers have been provided for your convenience, SMS is not responsible for personal items.

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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Are you currently under medical supervision? ○ Yes ○ No
If yes, please explain _____
Do you see a chiropractor? ○ Yes ○ No
If yes, how often? _____
Are you currently taking any medication? ○ Yes ○ No
If yes, please explain _____
Please check any condition listed below that applies to you:

- ○ contagious skin condition
- ○ open sores or wounds
- ○ easy bruising
- ○ recent accident or injury
- ○ recent fracture
- ○ recent surgery
- ○ artificial joint
- ○ sprains/strains
- ○ current fever
- ○ swollen glands
- ○ allergies/sensitivity
- ○ heart condition
- ○ high or low blood pressure
- ○ circulatory disorder
- ○ varicose veins
- ○ atherosclerosis
- ○ phlebitis
- ○ deep vein thrombosis / blood clots
- ○ joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis
- ○ osteoporosis
- ○ epilepsy
- ○ headaches/migraines
- ○ cancer
- ○ diabetes
- ○ decreased sensation
- ○ back/neck problems
- ○ Fibromyalgia
- ○ TMJ
- ○ carpal tunnel syndrome
- ○ tennis elbow
- ○ pregnancy
  If yes, how many months? _____

Please explain any condition that you have marked above _____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

I, _____ (print name) 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 this session, I will immediately inform the 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 and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

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