



# Client Intake Form

Bliss Spa & Boutique  
490 S Maple St – French Lick, IN  
812-936-2639

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone: \_\_\_\_\_ Email \_\_\_\_\_

DOB: \_\_\_\_\_ How did you hear of us? \_\_\_\_\_ Occupation \_\_\_\_\_

If receiving a massage, have you ever received a professional massage? YES NO  
What is your preferred massage pressure? Light Medium Firm

If receiving a facial treatment, have you ever received a professional facial? YES NO  
If yes, when? \_\_\_\_\_

What are your massage goals? (if applicable) \_\_\_\_\_

What are your facial goals? (if applicable) \_\_\_\_\_

### If answering "Yes" to any of the following please explain in comments?

Do you suffer from headaches?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you bruise easily?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have diabetes?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Have you broken any bones in the past 2 years?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you suffer from stress?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Any injuries in the past 2 years?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you pregnant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Any cardiac or circulatory problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you suffer from arthritis?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you suffer from back pain?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you wear contact lenses?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you have any numbness or stabbing pains?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you wear dentures?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Have you ever had surgery?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have high blood pressure?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you have tension in specific areas?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you take high blood pressure meds?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you sensitive to touch in any areas?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you suffer from epilepsy or seizures?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Any medical conditions of concern?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you suffer from joint swelling?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you have osteoporosis?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have varicose veins?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you have any contagious diseases?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Comments: \_\_\_\_\_

I understand that the treatment I receive is provided for the basic purpose of relaxation and relief of the specific treatment areas. If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that the pressure and/or treatment can be adjusted to my level or comfort. I further understand that the treatment I receive should not be construed as a substitute for medical examination, diagnosis, or prescribed treatment that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that the practitioner assigned to me is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such. Because treatments 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made towards my practitioner will result in an immediate termination of the session, and I will be 100% liable for payment of the scheduled appointment.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature \_\_\_\_\_

Minor Consent Signature \_\_\_\_\_

I have read the above information and give permission for my child, age \_\_\_\_\_ to receive a treatment from a Bliss Spa practitioner.