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?

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

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.