

*Ayala Wellness*  
Massage & Cleansing

**Massage Client Intake Form**

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phones: \_\_\_\_\_ Home: \_\_\_\_\_ Office: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email Address (please write clearly): \_\_\_\_\_  
Occupation/Employer: \_\_\_\_\_  
How did you find out about us? \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
  
Have you had a massage before? \_\_\_\_\_ If so, when? \_\_\_\_\_  
How Often? \_\_\_\_\_ Where? \_\_\_\_\_  
How was the experience? \_\_\_\_\_  
What is your goal for today? \_\_\_\_\_  
What type of pressure do you like? (Please Circle) Light----Medium----Firm----Deep  
Are you *uncomfortable* with any of the following areas to be massaged:  
*Gluteal Region (Y/N) Pectoral Region (Y/N) Face/Scalp (Y/N) Feet (Y/N)*  
Stress level (circle one): mild moderate high

**Health History**

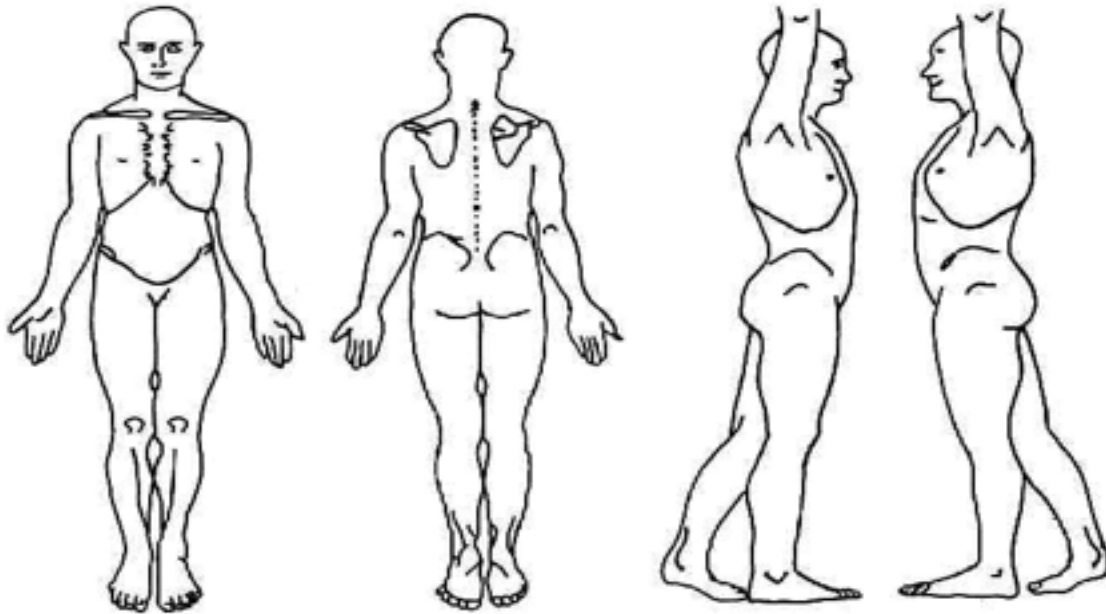
Please list any medications or supplements you are currently taking and explain:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any injuries/accidents/illnesses still affecting you:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any conditions or side-effects you have and/or medications you are taking associated with these conditions:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries and explain:  
\_\_\_\_\_  
\_\_\_\_\_

Please identify the areas of concern on the chart below:



Please check all that apply:

- headaches             neck pain             back pain             varicose veins
- jaw clenching / teeth grinding             leg/knee pain             seizures
- bruise easily             high blood pressure             wear eye contacts
- diabetes             fibromyalgia
- numbness / tingling, if so: where? \_\_\_\_\_
- active cancer

Do you have any allergies and/or skin sensitivities?  Yes  No

If yes, please list: \_\_\_\_\_

Our lotion products may contain nut oils. Are you allergic to nut or nut products?

Yes  No

If yes, please list the types of nuts: \_\_\_\_\_

Are you pregnant or trying to become pregnant?  Yes  No

If so, how many weeks: \_\_\_\_\_ approximate due date: \_\_\_\_\_

Postpartum two years or less?  Yes  No Birth Date \_\_\_\_\_

Any additional medical issues you would like us to know about?

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**Release Form**

By signing this, I, \_\_\_\_\_ agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnosis any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made I will inform the therapist, so he/she may direct me to another treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate the massage.

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I will be charged the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, he/she will fulfill the scheduled massage length or offer a reasonable compensation.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

I hereby agree that I am responsible for my health and the services received here.

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

### **AYALA WELLNESS GUIDELINES & POLICIES**

- ♥ Please help keep this a chemical free space and avoid the use of perfumes, products or Smoking of any sort prior to your visit. Thank you for considering others.
- ♥ Please arrive in a calm, relaxed state on time for your appointments. Thank you!
- ♥ Please respect our scheduled appointment time. I request 24-48 hours notice if you wish to reschedule or cancel. Appointments rescheduled or canceled less than 24 hours in advance will be charged as a missed appointment and billed at the full rate.
- ♥ If you have any questions or concerns before this appointment, please call me.

**Many blessings of health and joy to you!**