THE SPA AT RHYTHM CITY CASINO RESORT

Date:_____

CLIENT INTAKE FORM - THERAPEUTIC MASSAGE

Personal Information:

Name:_____ Day Phone: _____ Evening Phone:_____

Address: _____

City: _____ State: _____ Zip Code: _____

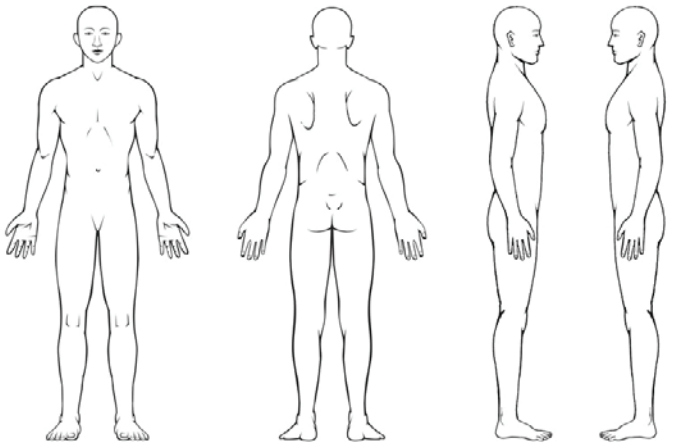
Email: _____ Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Massage:

Date Of Initial Visit:_____

1. Have you had a professional massage before? Yes _____ No _____
   If yes, how often do you receive massage benefits: _____
2. Do you have any difficulty lying on your front, back or side? Yes _____ No _____
   If yes, please explain: _____
3. Do you have any allergies to oils, lotions or ointments? Yes _____ No _____
   If yes, please explain: _____
4. Do you have sensitive skin? Yes _____ No _____
5. Are you wearing contact lenses? Yes _____ No _____ Dentures? Yes _____ No _____ Hearing Aids? Yes _____ No _____
6. Do you sit for long hours at a workstation, computer or driving? Yes _____ No _____
   If yes, please describe: _____
7. Do you perform any repetitive movement in your work, sports or hobby? Yes _____ No _____
   If yes, please describe: _____
8. Do you experience stress in your work, family or other aspect of your life? Yes _____ No _____
   How do you think it has affected your health? _____
   Muscle Tension _____ Anxiety _____ Insomnia _____ Irritability _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   _____
   _____
   _____
10. Do you have any particular goals in mind for this massage session? Yes _____ No _____
    If yes, please explain: _____
    _____
    _____
11. Circle or indicate any areas you would like the massage therapist to concentrate on during the session on the diagram to the right.



Medical History

In order to plan a massage session that is safe and effective, some general medical history is required.

1. Are you currently under medical supervision? Yes _____ No _____
   If yes, please explain: _____

2. Do you see a chiropractor? Yes _____ No _____
   How often? _____

3. Are you currently taking any medication? Yes _____ No _____
   Please list: _____

Please check any condition listed below that applies to you:

_____contagious skin condition	_____ phlebitis	_____deep vein thrombosis / blood clots
_____open sores or wounds	_____ easy bruising	_____joint disorder/rheumatoid arthritis/osteoarthritis
_____tendinitis	_____ osteoporosis	_____recent accident or injury
_____recent fracture	_____ epilepsy	_____recent surgery
_____headaches/migraines	_____ artificial joint	_____cancer
_____sprain/strains	_____ diabetes	_____current fever
_____decreased sensation	_____ swollen glands	_____back/neck problems
_____allergies/sensitivity	_____ fibromyalgia	_____heart condition
_____TMJ	_____ tennis elbow	_____high or low blood pressure
_____carpal tunnel syndrome	_____ varicose veins	_____circulatory disorder
_____atherosclerosis	_____ pregnancy - how many months?_____	

Please explain any condition you have marked above:_____

_____

_____

4. 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 parent or legal guardian for any client under the age of 17.

I, _____, 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 spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given 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 part of the therapist or Rhythm City Casino Resort should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Massage Therapist: _____ Date: _____