

Vibrance Medical Spa
Massage Intake Form

Name: _____ Date: _____
Address: _____
City _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Occupation: _____

Gender: M F

Please let us know your email address if you are interested in receiving information from our spa regarding upcoming VIP events, monthly specials and educational information on health and beauty.

Email: _____

How were you made aware of our medical spa?

Phonebook Dr. Freed Website Mailer Magazine Word of mouth Other

Medications

Please check the following medications/supplements you are currently taking:

Blood thinners (Coumadin, Aspirin, Plavix)

Heart related meds (Atenolol, Propranolol, Diltiazem, Verapamil, or any other beta blockers)

Blood pressure medications

Past Medical History

Have you ever had the following?

Osteoporosis

Heart Disease

Arthritis

Cancer

Asthma

Tuberculosis

Diabetes

High Blood Pressure

Stroke

Kidney Disease

Thyroid Disease

Bleeding tendency

AIDS or HIV

Hepatitis

Review of Systems

Please check the following symptoms that you currently have or have had within the past year.

- Skin rash
- Joint or muscle pain
- Swollen lymph nodes
- Rapid heart beat
- Chronic Cough
- Chest Pain

Other Information

Are you currently pregnant or attempting to get pregnant? Yes No

Are you on a regular exercise routine? Yes No

Do you follow a healthy diet? Yes No

Approximately how many glasses of water do you drink each day? _____

Have you ever had a massage before? Yes No

If yes, how frequently do you receive them? _____

Please check the following areas that you would like addressed today:

- Head and neck
- Upper back
- Lower back
- Legs