Bella Soul Spa

Massage and Spa Health Intake Form

Name_____ Date_____
Email_____ Date of Birth_____
Referred by_____
Home Address_____
City_____State_____ Zip Code_____
Phone (to be used for reminder/follow up calls) _____
Emergency Contact_____ Phone_____

What would you like to accomplish with your treatment?_____
_____
List areas of pain, focus, and concern:_____
_____
List other alternative care modalities you are receiving:_____
_____
Fitness Regimen:_____
_____
List all medications and supplements:_____
_____
List any surgeries, accidents, or major illnesses:_____
_____
(If you need more space, please use the back of this form)
List all allergies including plant/vegetable products, cosmetics and medications:
_____

Cancellation Policy

Your appointment is a special time reserved just for you and we hope you do not have to cancel. However, in the case that you do need to cancel or reschedule, please let us know 24 hours ahead of your scheduled appointment time to avoid being charged 50% of your scheduled treatment(s). Future appointments may not be made until fee is paid in full.
Please
initial_____

Consent For Care

It is my choice to receive treatment and I give my consent. I have reported all health conditions and medications that I am aware of and will inform my therapist of any changes in my health.

Signature_____Date_____
Parent/Guardian_____Date_____

Therapist Notes: