



Diva Package Intake

Celestial Spa
On Cloud 9

Therapist Notes

(To be completed by therapist)

Name: _____

Date: _____

Service: _____

Notes: _____

First & Last
Name _____

Email _____ @ _____

Phone _____
(M) _____

Address _____

Birth day: ____/____/____

Employer/Occupation: _____

First professional massage? Yes No

How frequently do you get a massage? _____

Massage preference? Light Medium Firm Unsure _____

Are you currently under the care of a physician? Yes no
Please list any current medical conditions for which you are under a
physician's care:

Allergies: _____

Are you currently pregnant? If so, how many weeks?

Yes No

List any specific areas of concern

Please state any recent injuries,
surgeries, accidents or medical
treatments:

For your Facial: Please circle all that apply

Skin type: Dry Oily Combination

Skin Conditions: sunburn easily redness acne breakouts flaking
tightness

Please list any skincare concerns you would like to discuss with your
Esthetician

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I, also, understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: _____

Date: _____