Confidential Client Intake Form

Name_____Date:_____

Address _____ City _____ St _____ Zip_____

Home Number _____ Work _____ Cell_____

Date of Birth _____ Occupation _____

Marital Status: _____Children _____ Email Address _____

Emergency Contact: Name _____ Phone# _____Relationship_____

How Did You Hear About Me? Referred by Whom? _____

Website _____Internet _____ Sign_____ Other _____

Current Complaints

_____

Surgeries in last 5 years

_____

List Medications and or Medical Conditions

_____

_____

Have you had a massage before? Yes ____ No ____

Are you Pregnant? NO _____Yes ____(due date _____)

I understand that I am responsible for honoring my commitment to my appointment and therapist. If an appointment is not cancelled 24 hours prior to the scheduled time and rescheduled for the next week or soonest available time, I am responsible for payment of the full amount of the session. I understand that if I am late, I will only receive service for the allotted time and will pay for the entire session.

Please inform your therapist if any medical conditions change or occur

I understand that massage therapy does not diagnose, prescribe medical treatment or perform spinal manipulations.

Signature _____ Date _____