

Client Intake Form

All Information Strictly Confidential

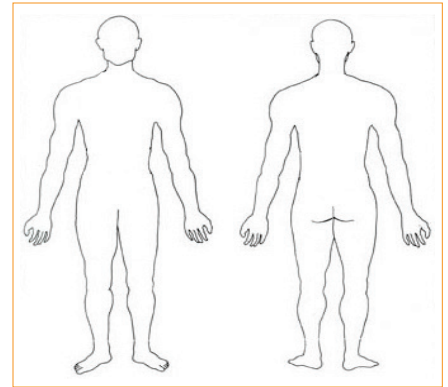
Name _____
Address _____
City _____ State _____
Zip _____
Contact Phone (_____) _____ - _____

Date of Birth _____
Emergency Contact: _____
Phone: _____
Referred By _____

Email (for appointment reminders) _____

Area of Pain

Please note on the bodies to the right where you are feeling pain or discomfort.



Occupation _____

Inform me of weekly appointment openings Yes No

Send me Special Promotions Yes No

Subscribe me to the monthly newsletter Yes No

I would like Studio Rewards Yes No

Medical Conditions and ALL Current Medications

If you currently have or have had any of the following medical conditions or incidents, please indicate type of condition if necessary and year of occurrence. Some medical conditions and medications may be contraindicated by massage.

Cancer (type) _____ Stroke _____

Have you ever had a professional therapeutic massage? Yes No

Diabetes _____ High Blood Pressure _____

If yes, what type (Swedish, Deep Tissue, Cranial Sacral, etc.) _____

Heart Attack or Disease _____ HIV/AIDS _____

Pregnancy _____ Fibromyalgia _____

Migraine or tension headaches _____ Phlebitis _____

Osteo- or Rheumatoid Arthritis _____

Are you allergic or sensitive to aromatherapy or nut oils? Yes No

Surgery (type) _____

Are you sensitive to heat or cold? Heat Cold Both No

Do you have any recent injuries? _____

Medications _____

Additional comments? _____

Dr. Name _____

Dr. Phone (_____) _____ - _____

I understand that the services of the therapist are not a substitute for professional medical care. If needed, I grant permission for the therapist to contact my referring doctor (if applicable) regarding my sessions for my health and safety. I understand that you reserve the right to refuse service to any person for any reason, or not treat any area or condition through our therapies that you feel would have adverse effects on me. I understand that if being referred by a physician for treatment, the therapist will defer to that physician's orders as the primary goal of treatment. **Cancellation Policy:** We require 24 hours advanced notice of cancellation. No-show, missed appointments will be charged for the full session, and a late cancellation fee of \$25 may be charged in the event of a cancellation less than 24 hours if the appointment cannot be filled with another client. If arriving late for an appointment, the session will still end on time, with full payment due. I have read and understand the cancellation policy and guidelines outlined above regarding treatment. I understand that The Neuromuscular Studio occasionally takes a posts pictures on social media accounts, and my image may be seen online in these accounts.

Client Signature _____

Date _____