Client Intake Form

All Information Strictly Confidential

Name ______________________ Date of Birth ______________________

Address ______________________ Emergency Contact ______________________

City ____________ State ________ Phone ______________________

Zip ______________________ Referred By ______________________

Contact Phone (______) ________ - ________

Email (for appointment reminders) ______________________

Occupation ______________________

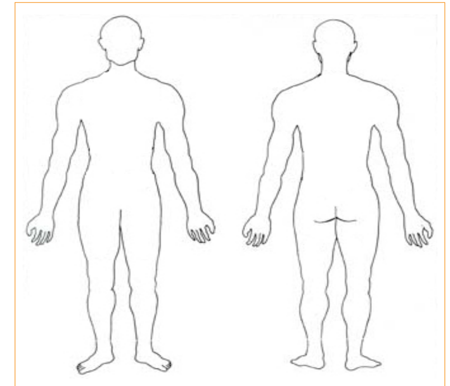
Inform me of weekly appointment openings ☐ Yes ☐ No

Send me Special Promotions ☐ Yes ☐ No

Subscribe me to the monthly newsletter ☐ Yes ☐ No

Area of Pain

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



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 occurance. Some medical conditions and medications may be contraindicated by massage.

Cancer (type) ____________ Stroke ____________

Diabetes ____________ High Blood Pressure ____________

Heart Attack or Disease ____________ HIV/AIDS ____________

Pregnancy ____________ Fibromyalgia ____________

Migraine or tension headaches ____________ Phlebitis ____________

Osteo- or Rheumatoid Arthritis ______________________

Surgery (type) ______________________

____

Medications ______________________

____

____

Dr. Name ______________________

Dr. Phone (______) ________ - ________

Previously had a professional therapeutic massage ☐ Yes ☐ No

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

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Allergic or sensitive to aromatherapy or nut oils ☐ Yes ☐ No

Sensitive to heat or cold ☐ Heat ☐ Cold ☐ Both ☐ No

Do you have any recent injuries? ______________________

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Additional comments? ______________________

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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.

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Client Signature Date

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Neuromuscular Studio

Certified Neuromuscular and Medical Massage Therapy