Client Intake Form

IF YOU ARE NOT FEELING WELL OR HAVE RECENTLY TRAVELED OUT OF STATE PLEASE RESCHEDULE YOUR APPOINTMENT!

PERSONAL INFORMATION

NAME

EMAIL

ADDRESS	CITY	STATE	ZIP

OCCUPATION	DATE OF BIRTH

HOW DID YOU HEAR ABOUT US?

MOBILE PHONE	HOME PHONE	WORK PHONE

EMERGENCY CONTACT & PHONE NUMBER

MEDICAL CONDITIONS

______ Arthritis	______ Autoimmune	______ Bruise easily	______ Cancer
______ Car Accident	______ Carpal Tunnel	______ Depression	______ Diabetes
______ Disc Problems	______ Epilepsy	______ Headaches/Migraines	______ Heart condition
______ High/Low Blood Pressure	______ Numbness/Tingling	______ Old injuries	______ Plantar Fasciitis
______ Plantar Warts	______ Rotator cuff injury	______ Sciatica	______ Scoliosis
______ Sinus Problems	______ TMJ	______ Varicose Veins	______ Skin conditions

REASON FOR INITIAL VISIT

Have you had a massage before? YES NO

Injuries or Surgeries in the past? YES NO

PLEASE DESCRIBE

ALLERGIES OR SKIN SENSITIVITIES

MEDICATIONS

Pregnant? YES NO How far along?

Areas you would NOT like to be worked on:

______ Back	______ Neck	______ Shoulders	______ Hips	______ Gluts	______ Face
______ Feet	______ Arms	______ Hands	______ Scalp	______ Abdomen	______ Other

LEGAL INFORMATION

By Signing Below, I Agree That I Have Read And Understand The Following:

The above information is accurate to the best of my knowledge, and I freely give my permission to the therapist of my choice. I agree to inform the therapist of any experience of pain or discomfort during the session. I understand this does not deter me from seeking medical treatment for medical conditions.

CLIENT BEHAVIOR:

I understand that no inappropriate comments or conduct will be tolerated. Any indications of such behavior will automatically end the session.

NO LIABILITY

I understand that the therapist of my choice does not diagnose illness, disease or any other physical or mental disorder. As such the therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that services received are not a substitute for any physical ailment that I might have, or a substitution for medical examination and/or medical diagnoses.

Because a therapist must be aware of existing physical conditions, I have stated all my known medical conditions. I take it upon myself to keep the therapist updated on any changes to my health, and any recommendations and/or restriction on the part of my medical doctor or other therapist.

SIGNATURE	DATE

Service Record

CLIENT NAME	
PHONE NUMBER	

Date	PRACTITIONER/ THERAPIST	NOTES	SERVICE CODE	FEE	THERAPIST SIGNATURE

Service Codes: GN=Groupon **CN**=Coffee News **J**=Julies Cafe **P**=The Press **BF**=Bay Family