



Client Intake Form – Maintenance Massage

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: () _____ Work #: () _____ Cell #: () _____
 E-mail: _____ Social Security #: _____
 Emergency contact: _____ Relationship: _____ Phone: () _____
 Referred by: _____

General & Health Information

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | | | | | |
|-----|----|--|-----|----|--|
| Yes | No | Have you ever had a professional massage? | Yes | No | Have you had any broken bones in the past 2 years? |
| Yes | No | Do you experience frequent headaches? | Yes | No | Do you have tension or soreness in a specific area? |
| Yes | No | Are you wearing contact lenses? | Yes | No | Do you have cardiac or circulatory problems? |
| Yes | No | Are you diabetic? | Yes | No | Do you suffer from back pain? |
| Yes | No | Do you have high blood pressure? | Yes | No | Are you very sensitive to touch/pressure in any area? |
| Yes | No | If you have high blood pressure,
are you taking medication for this? | Yes | No | If female, are you pregnant? |
| Yes | No | Are you currently being treated for cancer? | Yes | No | Do you suffer from seizure disorders or epilepsy? |
| Yes | No | Do you have any other medical conditions
your massage therapist should be aware of? | Yes | No | Have you ever had surgery? If yes,
please explain in the comments areas of this form. |

Comments:

Appointment Reminder Would you like to receive an appointment reminder? Yes No
 If yes, how? E-mail Phone: Home Work Cell Text

Payment Method How will you be paying for this visit? Cash Check Credit Card (MC/Visa/Disc) Gift Certificate
Payment is due at the time of service, unless otherwise arranged. There is a \$35 Returned Check Fee.

I hereby authorize the release of medical information necessary to comply with regulations. This may include intake forms, chart notes, reports, correspondence, billing statements, and any other information to attorneys, health care providers and others as provided by law.

Signature: _____ Date: ____ / ____ / _____

Financial Agreement

I hereby acknowledge that I am responsible for full payment of my account.
 If I do not call 24 hours before my scheduled appointment to cancel, I am responsible for paying In Touch Therapy for the missed appointment.

Signature: _____ Date: ____ / ____ / _____