Client Intake Form

All Information Strictly Confidential

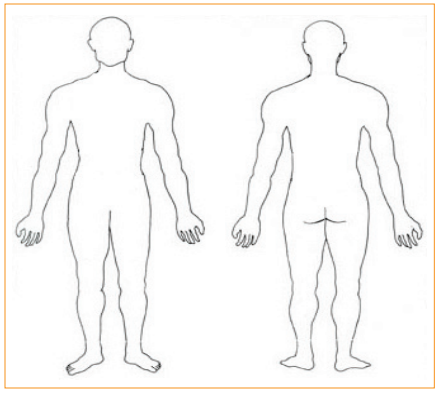
Name _____
Address _____
City _____ State _____
Zip _____
Home Phone (_____) _____ - _____
Cell phone (_____) _____ - _____
Email (for appointment reminders) _____

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

Inform me of appointment openings? Yes No (please circle one)
Send me special promotions? Yes No (please circle one)

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 (_____) _____ - _____

Have you ever had a professional therapeutic massage? Yes No
If yes, what type (Swedish, Deep Tissue, Cranial Sacral, etc.) _____

Are you allergic or sensitive to aromatherapy or nut oils? Yes No
Are you sensitive to heat or cold? Heat Cold Both No
Do you have any recent injuries? _____

Additional comments? _____

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.

_____

Client Signature Date

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Neuromuscular Studio
Certified Neuromuscular and Medical Massage Therapy