Client Intake

Name:_____	Today's Date:_____
Email:_____ Primary Phone:_____ Date of Birth:_____ Address: _____	Emergency Contact:_____ Phone:_____
(OFFICE USE ONLY) Notes:	

Have you received professional bodywork before? _____ If yes, please list types, usual frequency, and most recent treatment (include osteopathic, chiropractic, acupuncture, etc.)_____

_____

_____

Please list any forms of relaxation and/or exercise you are currently engaged in:(e.g. yoga, dance, boxing, etc.)_____

_____

_____

Please list any surgeries, major illnesses, injuries or accidents you have had:_____

_____

_____

Are you currently taking any medications? If yes, please list:_____

_____

Are you pregnant?____ Wearing contacts?____ Wearing dentures?_____

(OVER)

Please mark all previous/current conditions that you have/have had:

Cancer and/or tumors___Hepatitis A, B, or C___Extreme fatigue___ Diabetes(Do you have your kit? Y/N)___Varicose or spider veins___Rapid weight loss___Asthma?(Do you have your inhaler? Y/N)___Seizures or convulsions___Contagious infection or disease___Heart problems___ Sciatica___Numbness or tingling___Back or spinal problems___Bone or joint problems___Arthritis(type:_____)___Blood clots, phlebitis, or inflammation of the blood vessels___Allergies, allergy symptoms, chemical sensitivities___Skin infections, rashes, cuts, bruises, sores, warts___High/low blood pressure___Temporomandibular Joint Disorder(TMJ)___Hearing, sight or speech impediments___

PURPOSE & LIMITATIONS OF BODYWORK

I, _____(name), understand that professional bodywork is for the purpose of stress reduction, muscular tension relief, general relaxation, and improvement of joint mobility and circulation. I understand that the therapist does not diagnose illness, disease or any other physical or mental disorders. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he perform spinal manipulations. I understand that massage therapy is not a substitute for medical treatment, and that it is recommended I see a physician for any physical ailments. I have stated all of my known medical conditions and take it upon myself to keep the therapist updated on my physical health. By signing below I am stating that I understand and agree to the terms of massage stated above.

PAYMENT TERMS

Payment in full is required at time of service unless other payment arrangements have been made prior to appointment. Cancelation within 24 hours is required to avoid payment for session. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all legal costs and expenses including reasonable attorney's fees. I hereby authorize Peter Gold, LMT to release all and any information necessary to secure payment.

Client Signature: _____ Date:_____