

Massage Intake Form - CONFIDENTIAL INFORMATION

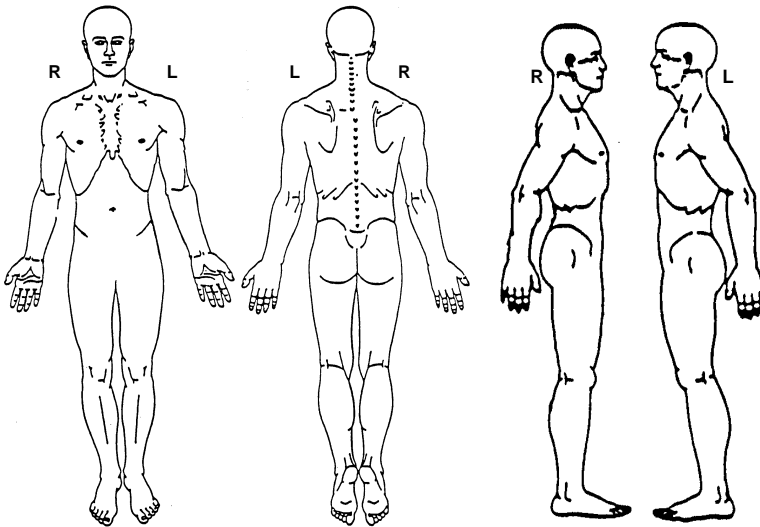
RENEW Use Only

Please list **all medications** and nutritional supplements you are taking: _____

Notes:

Please list all surgeries in your lifetime:

Please color in your conditions, scars and injuries etc *PLEASE note any areas you'd like to request massaged (face, abdominals, glutes):



List other therapies you currently receive: _____

Please list any additional comments regarding your health and well-being:

Must give 24 hour notice of cancellation or full payment will be expected.

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Home Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Home Phone # _____

Mobile Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

How did you find us? _____

The information I have provided is accurate and complete to the best of my knowledge. I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation I receive in this clinic or from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them. I understand that no sexual activity, comment or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc, without explanation or prior notice, and I agree to this policy. Cancellation within 24 hours of scheduled massages may result in charge of up to the full price of your intended session. You may contact me for appointment reminders, schedule changes, or other needs.

Signature: _____ Date: _____

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