

CLIENT INTAKE FORM

ABOUT YOU	NAME		EMAIL	
	ADDRESS		CITY	STATE ZIP
	YOUR OCCUPATION		DATE OF BIRTH	
	HOW DID YOU HEAR ABOUT US?			
	MOBILE PHONE	HOME PHONE	WORK PHONE	
	EMERGENCY CONTACT NAME & TELEPHONE NUMBER			
	HOW YOU WOULD LIKE TO BE NOTIFIED OR REMINDED OF YOUR APPOINTMENTS?			
CHECK ALL THAT APPLY <input type="checkbox"/> by TELEPHONE _____ <input type="checkbox"/> by TEXT _____ <input type="checkbox"/> by EMAIL _____				
HEALTH HISTORY	MEDICAL CONDITIONS – PLEASE CHECK ALL CONDITIONS THAT APPLY			
	<input type="checkbox"/> headaches	<input type="checkbox"/> neck pain	<input type="checkbox"/> back pain	<input type="checkbox"/> jaw clenching/teeth grinding
	<input type="checkbox"/> leg / knee pain	<input type="checkbox"/> seizures	<input type="checkbox"/> bruise easily	<input type="checkbox"/> high blood pressure
	<input type="checkbox"/> varicose veins	<input type="checkbox"/> wear hearing aid	<input type="checkbox"/> diabetes	<input type="checkbox"/> fibromyalgia
	<input type="checkbox"/> active cancer	<input type="checkbox"/> numbness / tingling, if so: where?		
	Please list any conditions or side-effects you have and/or medications you are taking associated with these conditions			
	Accidents, injuries and/or surgeries in the last two years? Please list, including date of occurrence			
	Are you pregnant?		Postpartum two years or less?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks: _____ due date _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, birth date _____	
	Do you have any allergies and/or skin sensitivities?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:				
Indicate the depth of pressure and intensity you prefer:		Are you comfortable with these areas being massaged?		
<input type="checkbox"/> Light pressure <input type="checkbox"/> Medium pressure <input type="checkbox"/> Deep pressure		<input type="checkbox"/> face <input type="checkbox"/> scalp <input type="checkbox"/> chest <input type="checkbox"/> glutes <input type="checkbox"/> abdomen		
TERMS AND CONDITIONS	LEGAL INFORMATION: BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING:			
	I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.			
	CLIENT BEHAVIOR			
	Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for FULL PAYMENT.			
	EMAIL POLICY			
We will use your email address for appointment reminders, promotions and news from Body Balance & Harmony. Your privacy is important to us. We will not sell, rent, or give your name or address to anyone. To unsubscribe, simply call us or send us an email.				
CLIENT INFORMATION				
Body Balance & Harmony treats client information as private and complies with applicable laws that protect the privacy and security of clients' personal data.				
SIGNATURE			DATE	