

A Touch of Heaven, Massage Therapy
Client Intake Form

Last Up Date - 2011

Name: _____ Date _____

Address: _____ Date of Birth ___ / ___ / ___

Phone: (Home) _____ (Work) _____ (Cell) _____

E-Mail Address _____
(Email addresses will be used only for ATOH informative information, newsletters, massage reminders and coupon specials and will not be used for any other purpose nor will it be distributed or sold to any third party.)

Who may we thank for referring you? _____

Are you under a physician's care? Yes ___ No ___ If Yes, explain: _____

Have you had any surgery in the last month? Yes ___ No ___ If Yes, explain: _____

Are you taking any medications? Yes ___ No ___ If Yes, please list and the or conditions associated with the medications _____

Do you have any allergies? If so, please list: _____

Have you ever received a professional massage? Yes ___ (Last massage date)-Approx _____ No ___

Please check off any of the following conditions that you are experiencing:

Muscle Tightness or Soreness _____ Trouble Sleeping _____ Restless Legs _____ Inflammation _____

Anxiety _____ Headaches _____ Stress _____ Recent Injury _____ Are you pregnant? Yes ___ No ___

Tension _____ Aching Legs _____ Contagious Disease _____ Arthritis _____ Sinus Issues _____

Sinus Issues _____

Other: Is there a specific body area on which you would like the therapist to concentrate?: (example: shoulders, neck, low back, etc.) _____

What results would you like to achieve? _____

If you have received any other treatment for your condition, please check any that apply:
Medication _____ Surgery _____ Physical Therapy _____ Chiropractic Care _____ Other _____

I understand that this is a professional massage/reflexology session and is in no way, sexual in nature. If the practitioner feels that any inappropriate gestures are made by the client, he/she reserves the right to end the session immediately, with payment due in full.

I understand that Massage and Reflexology are compliments to healthcare and not a substitute for medical supervision of any condition. If I have any medical condition that requires a physician's care, I have consulted him/her regarding receiving a Massage/Reflexology treatment, and either have their consent, or have taken responsibility for the session upon myself. I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

Signed: _____ Date: _____