elements
therapeutic massage

Elements Therapeutic Massage **Intake Form**

PERSONAL INFORMATION

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone numbers (c):_____ (h): _____ (w): _____
e-mail address*: _____

How would you like to be notified of your appointments?
❍ telephone ❍ e-mail ❍ mobile text message (*standard carrier rates may apply, list carrier name*:_____)

May we leave a phone message with another person at the above phone number(s)? ❍ Yes ❍ No

How did you hear about Elements Therapeutic Massage?: _____
Occupation: _____ Date of Birth: _____

MEDICAL AND HEALTH INFORMATION

Emergency contact name and telephone number:_____

Are you enrolled in a Section 125 Health Savings Account (HSA), Flexible Spending Account (FSA), or Health Reimbursement Account (HRA)? ❍ Yes ❍ No

Please check all that apply:

❍ headaches ❍ neck pain ❍ back pain ❍ jaw clenching / teeth grinding
❍ leg / knee pain ❍ seizures ❍ bruise easily ❍ high blood pressure
❍ varicose veins ❍ wear eye contacts ❍ diabetes
❍ numbness / tingling, if so: where? _____
❍ active cancer, if so please request and complete the Oncology Intake Form.

Do you have any allergies and/or skin sensitivities? ❍ Yes ❍ No
If yes, please list:_____

Our lotion products may contain nut oils. Are you allergic to nut or nut products? ❍ Yes ❍ No
If yes, please list the types of nuts: _____

Accidents, injuries and/or surgeries in the last two years? Please list, including date of occurrence:

_____

_____

Please list any conditions or side-effects you have and/or medications you are taking associated with these conditions:

_____

Are you pregnant or trying to become pregnant? ❍ Yes ❍ No
If yes, how many weeks: _____ Approximate Due Date: _____

Postpartum two years or less? ❍ Yes ❍ No Birth Date _____

Are there any additional medical issues we should know about? _____

_____

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. 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.
Cancellation Policy: Should I cancel or miss an appointment with less than 24 hours notice, I authorize this Elements Therapeutic Massage® studio to charge my VISA/Mastercard/American Express/Discover Card or checking account for the full session fee.
E-mail Policy: We will use your e-mail address for appointment reminders, promotions and news from Elements Therapeutic Massage®. Your privacy is important to us. We will not sell, rent, or give your name or address to anyone. To unsubscribe, or to receive less or more information, you can select a link at the bottom of every e-mail.

_____ (Initial Here) I acknowledge that I have received Notice of HIPAA Privacy Practices.

Therapist Initials: _____

Signature: _____ Date: _____