

INTAKE FORM

ABOUT YOU	NAME					
	EMAIL					
	ADDRESS		CITY	STATE	ZIP	
	YOUR OCCUPATION			DATE OF BIRTH		
	HOW DID YOU HEAR ABOUT US?					
CONTACT	MOBILE PHONE		HOME PHONE		WORK PHONE	
	<input type="checkbox"/> OK to leave a message at the number above		<input type="checkbox"/> OK to leave a message at the number above		<input type="checkbox"/> OK to leave a message at the number above	
	EMERGENCY CONTACT NAME & TELEPHONE NUMBER					
	CIRCLE HOW YOU LIKE TO BE NOTIFIED OF YOUR APPOINTMENTS? SELECT ALL THAT APPLY <input type="checkbox"/> telephone <input type="checkbox"/> email <input type="checkbox"/> text message (list carrier)					
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"/> leg / knee pain		<input type="checkbox"/> seizures		<input type="checkbox"/> bruise easily	
	<input type="checkbox"/> varicose veins		<input type="checkbox"/> wear contact lenses		<input type="checkbox"/> diabetes	
	<input type="checkbox"/> active cancer (please ask for an Oncology Intake Form)		<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 or trying to become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks: _____ due date _____			Postpartum two years or less? <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:					
	Our lotion products may contain nut oils. Are you allergic to nut or nut products? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the types of nuts:					
Are there any additional medical issues we should know about? If you have an issue you do not wish to state on this form, please discuss it with your therapist.						
I have a Section 125 Health Savings Account (HSA), Flexible Spending Account (FSA), or Health Reimbursement Account (HRA)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
TERMS & 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.					
	NON-SOLICITATION POLICY I will not solicit, recruit, or encourage any person employed by this Elements Therapeutic Massage® studio for employment or the provision of services outside of the studio.					
	24 HOUR CANCELLATION POLICY Should I cancel or miss an appointment with less than 24 hours notice, I authorize this Elements Therapeutic Massage® to charge my VISA/MC/Amex/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.						
SIGNATURE		I acknowledge that I have received notice of HIPAA Privacy Practices or have been given the opportunity to review. _____ (Initial Here)		DATE		
				THERAPIST INITIALS		