Therapeutic Touch of Health, LLC

Client Intake Form

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Email _____

Contact Phone Numbers: Cell _____ Alternate Number _____

Occupation _____

Current Hobbies _____

Primary reason for visit _____

_____

Medical Information

Check the medical conditions that apply to you:

____ Accident Injury	____ Acute Pain	____ Arthritis
____ Cancer	____ Chronic Pain	____ Diabetes
____ Headaches	____ Heart Condition	____ Infectious Condition
____ High Blood Pressure	____ Osteoporosis	____ Skin Condition
____ Stroke	____ Varicose Veins	

Other medical conditions: _____

Previous surgeries include: _____

_____

Are you currently under the care of a medical health professional?_____

If yes, please provide doctor information:

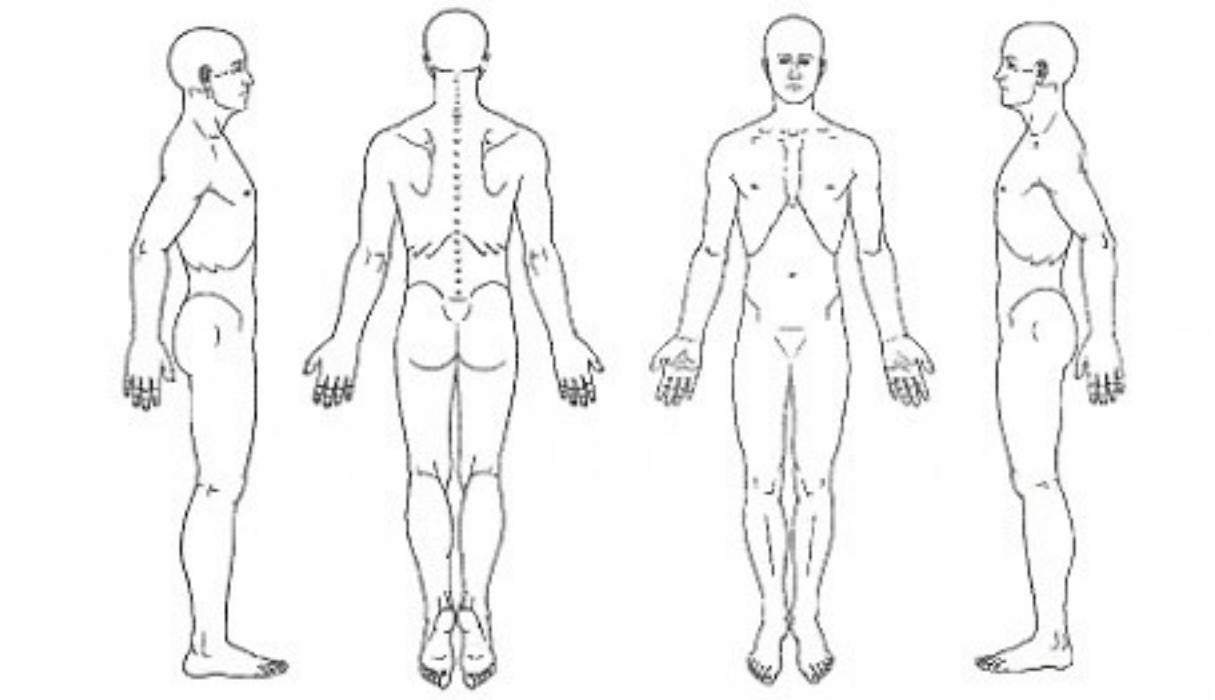
Doctor Name _____

Contact Phone Number _____

Current medications _____

Pain Diagram

On below body images circle those areas in which you are currently experiencing pain.



I understand the massage services I receive are provided for the basic purpose of relieving muscular tension. If I experience any pain or discomfort during the session, I will inform the therapist so that the pressure or strokes may be modified to my level of comfort.

I understand that massage should not be construed as a substitute for medical exam, diagnosis, or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any medical condition I am aware of.

Because massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapists' part should I forget to do so.

I understand that I will be financially responsible for payment in full for any unpaid balance not received from an insurance company or settlement for services rendered from Therapeutic Touch of Health, LLC.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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