501 Gateway Drive, Suite 104 • Clayton NC 27520
www.SpaNeoClayton.com • 919-550-9355

Massage Client Intake Form

Date: _____

Name: _____ _____ M _____ F

Address _____City _____ State_____ Zip _____

Home Phone #_____ Work phone #_____ Mobile phone #_____

Date of Birth _____/_____/_____ Age_____ e-mail _____

Marital Status: S M D W Spouse's Name _____ # of Children _____

Occupation _____ Employer _____

Job duties _____ ***"Stress"*** level ____low ____med ____high ____X-treme

Other Information

How were you referred to us?_____ Have you had professional massage before? Yes____ No___

Modality: _____ Swedish _____ Deep Tissue _____ Myofascial _____ Neuromuscular Other _____

What type of touch works best for you? ____Very light ____ Light ____ Medium ____ Firm ____ Very firm

Have you ever been on a regular massage ***"program"***? _____ How often between visits _____

How recently were you under this program? _____ Results _____

Reason for today's visit: ___ Relaxation ___ Stress relief ___ Muscle tension ___ Pain relief ___ Total health

____ Other Chief complaint: _____

Are you currently under medical care? ____Yes ____ No For: _____

Medical Doctor_____ Telephone # _____

Current Medications: _____

OLD accidents / injuries: _____

RECENT accidents / injuries: _____

Do you have or have you had any of the following: (please circle ***all*** that apply) **Very Important!!!**

Varicose veins	High blood pressure	**HIV / AIDS**	Headaches	Car accidents
Heart disease	Open cuts or wounds	Fibromyalgia	Abdominal pain	Joint aches
MS or MD	Breast Augmentation	Fungus/ Skin lesions	Allergies	Carpal tunnel
Cancer	**Dizziness / Passing out**	Bruises/ Bleeding	Back Pain	Arthritis / Bursitis
Diabetes	**Contagious disease**	Mastectomy	**Seizures**	Scoliosis
Blood clots	Whiplash / Neck pain	**Stroke**	Sciatica	Nervous tension

Other medical condition(s) / Explain: _____

Would you like to learn of the benefits of a regular Massage Therapy Program?_____

Have you ever received chiropractic care? _____ When / Results _____

Would you like to learn of the benefits of a regular program of Chiropractic care?_____

Financial Policy: Payment for massage is due at the time the service is received, unless other specific arrangements are made ***prior*** to the session beginning. If you have an insurance company that reimburses for Massage Therapy, we will provide you with a "superbill" to submit to your insurance company for reimbursement.

Cancellation Policy: The time of your appointment is reserved for you. If you cannot make your appointment, you must call us with at least a 24 hour notice or you will be billed for the cost of the hour. Any "No Show" appointments will be billed at the cost of the hour. Also, please arrive promptly for your visits so we can serve you the best we can and maximize the therapeutic value of your massage. If you are late for an appointment the time will be reduced from your massage if there is another patient scheduled after you!

I understand that I may be responsible for paying for any appointment cancellations of less than 24 hours.

ANY MISCONDUCT OR INUENDO WILL RESULT IN THE TERMINATION OF THE MASSAGE WITH ALL FEES DUE.

DO NOT alter any of your current medical care and continue to follow the advice of your medical or other healthcare providers.

I understand that this massage is not a replacement for medical or chiropractic care and that no claims of cure nor diagnosis are being made.

Signature _____ Date _____

Relationship (if minor is client) _____

TIPPING IS NOT NECESSARY BUT APPRECIATED.