INTAKE FORM

MASSAGE THERAPY

Date of First Session _____ Age _____ DOB _____

First Name _____ Last _____

Address _____ City _____ State/Zip _____

Email _____ Phone # _____

Occupation _____ Primary Physician _____

Have you seen one of the doctors at Natural Paths to Wellness? ○ Yes ○ No

If so which one? _____ Date of last appointment _____

MEDICAL INFORMATION

Are you taking any medications? If so, please list:

1. 4.

2. 5.

3. 6.

Are you currently pregnant? If so, how far along?

Do you have any health conditions your therapist should be aware of? If so, please list:

Do you suffer from chronic pain or have any orthopedic injuries. If so, please list:

Do you have any allergies or sensitivities? If yes, please list:

MASSAGE INFORMATION

Have you had a professional massage before? ○ Yes ○ No

If so, when was your last session? _____

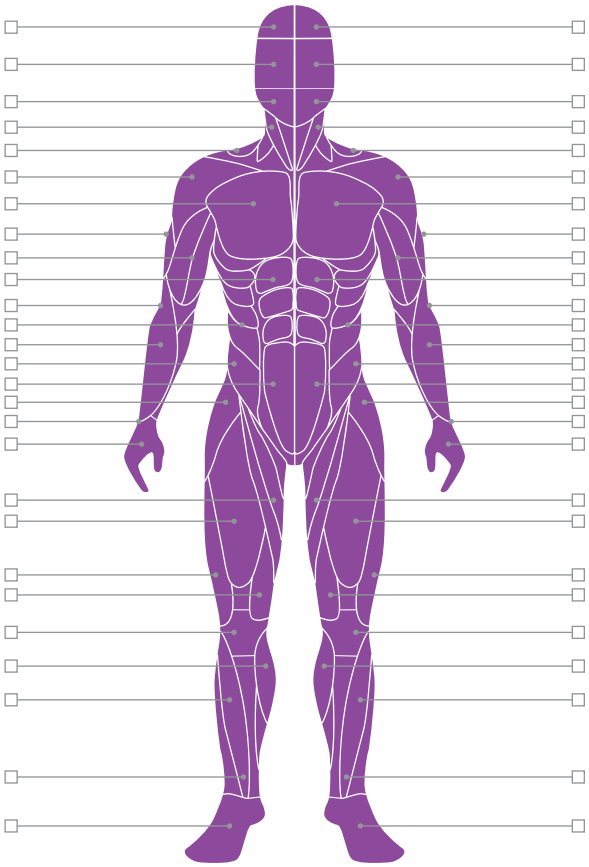
What type of massage treatment are you seeking? *Ex: relaxation, deep tissue, etc.*

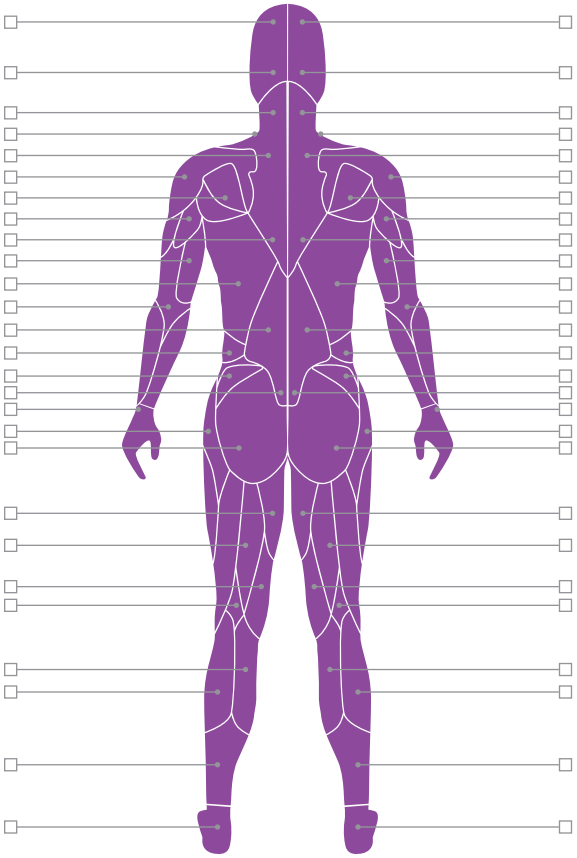
What pressure do you prefer? *Ex: light, medium, deep*

Are there any areas you do not want worked? *Ex: Glutes, scalp, feet, etc.*

What are your goals for this treatment session?

Please identify any areas of discomfort or tension below:





TREATMENT CONSENT

Please take a moment to read the following statements:

1. If I experience pain or discomfort during my session, I will immediately inform my therapist so they can adjust the pressure/strokes to my comfort level.

2. I understand that the services received are not a substitute for medical care. I understand that my therapist is not qualified to make a diagnosis, spinal adjustments, prescribe or treat any ailments.

3. I affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform my therapist of any changes in my health or medical conditions if they do occur.

INFORMATION & SUGGESTIONS

1. Prior to your massage, please remove glasses and all jewelry. Suggested to pull long hair back with a clip or hair band.

2. Please undress to your comfort level. Generally this is just undergarments, however, your therapist can meet you at your comfort level and adjust accordingly.

3. Feel free to ask questions before, during or after the session. You can always speak up and change things at any time.

By signing below I am agreeing that I have read the above statements and information provided. I have provided true and accurate information for my therapist in regards to my personal and health information.

THANK YOU!

At Natural Paths to Wellness, we understand that unanticipated events occur in everyone's life. In our commitment to provide a quality experience to all of our clients and out of consideration for our Nutritionist's time, we have adopted the following policies:

1. A credit card will be required for all new patient appointments to guarantee your appointment and reserve that time for you. Your card will not be charged unless you fail to provide 24 hours notice of cancellation, however, you may use it to pay for services at the completion of your appointment.

2. 50% of the amount of the services scheduled for a new patient appointment and 100% of the amount of services scheduled for a return appointment will be charged in full for clients who "no-show" or fail to cancel their reservation within a 24-hour time period. The determined amount will be charged to the credit card on file.

3. Financial responsibility for services you receive at the office is yours alone and is **due at the time of service**. Cash, check, debit cards, and all major credit cards (except American Express) are accepted as forms of payment.

4. Please arrive for your appointment(s) on or before your scheduled starting time. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

CONSENT OF FINANCIAL RESPONSIBILITY

I have read the above statement and understand that i am financially responsible to natural paths to wellness for all care and services provided to me and/or my dependents.

Signature: _____ Date _____

Submit this form to Admin@NaturalPathsToWellness.com or fax to 717.430.0016