

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: _____



Client Survey

How did you hear about Elements?

- Internet/Google search Postcard/Mailing Val Pak Drive By/sign
 Referral Other _____

If you were referred, please let us know by whom so that we can personally thank her or him:

Referral Name _____

What physical activities do you participate in regularly? This can help define areas that may require more attention during your massage:

- Cycling Golf Martial Arts/Kick boxing Pilates Yoga Running
 Swimming Tennis Walking Weight training Other _____

Have you had massage therapy before? Yes No

If you have had massage before, how often do you have massage therapy?

- Weekly A couple times per month Monthly 6 times or more per year
 6 times or less per year

What are you looking for from your typical massage? (Check all that apply)

- Relaxation Pain Relief Sport Specific Therapy While Undergoing Physical Therapy
 Deep Tissue Work Stress Management Other _____

I do not receive massage therapy more often because:

- Cost I neglect to schedule it Inconvenience Time

I would receive massage therapy more often if:

Are you aware that Elements offers a discounted month-to-month Massage wellness program and/or discounted massage packages? yes no