CORNERSTONE MASSAGE THERAPY

CLIENT INTAKE FORM

CLIENT INFORMATION

Last name:	First:	Middle:	Email address:

Street address:	Cell phone no.: ( )	Home phone no.: ( )

City:	State:	ZIP Code:	Birth date: / /

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by: ❑ Friend_____ ❑ Website ❑ Online Search ❑ Insurance Plan ❑ Window Sign ❑ Other

Emergency Contact:	Phone:

NGS OR BWC ONLY INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

ID No.:

HISTORY

Have you had a massage before? Y N If yes, how often/recently?

What is your goal for today's treatment?

Are you currently being treated for any medical conditions?

Surgeries? Accidents? Medications? Other?

24 HOUR CANCELLATION POLICY

I have reviewed a copy of the cancellation policy. Client initials_____

ACCEPTANCE

I understand that the massage/bodywork I receive is provided for the basic purposes of improving health and relieving muscular tension. If I experience any pain/discomfort during the session, I will immediately inform the therapist so that the treatment may be adjusted to my level of comfort. I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments or diagnose, prescribe or treat any mental or physical illness and that nothing said in the course of a session should be construed as such. Because massage/bodywork should not be performed 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 health status and understand there shall be no liability on the therapist's part should I forget to do so. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Cornerstone Massage Therapy or insurance company to release any information required to process my claims.

Client/Guardian signature *Date*