Wellesley Massage

Client Intake Form

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Physician: _____ Phone: _____

Significant Health Conditions: _____

Medications Being Taken: _____

Please indication any of the following conditions that you currently have:

- ☐ headaches
- ☐ cancer
- ☐ heart/circulation problems
- ☐ major accident
- ☐ neck/back injuries
- ☐ numbness
- ☐ allergies
- ☐ TMJ
- ☐ joint surgery
- ☐ varicose veins
- ☐ diabetes
- ☐ sprains, strains
- ☐ arthritis, tendonitis
- ☐ abnormal skin condition
- ☐ high/low blood pressure
- ☐ blood clots
- ☐ fibromyalgia
- ☐ recent injuries

Please explain any conditions you have marked above:

_____

_____

Cancellation Policy:

In order to meet my client's scheduling needs, 24 hours notice is required for all cancellations.

If 24 hours notice is not given, payment in full is expected.

Signature: _____ Date: _____