CLIENT INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION

Name: _____ D.O.B.: _____ Gender.: _____

Address: _____ City/State/Zip: _____

Primary Contact #: _____ Email: _____

Marital Status: _____ Children's Names/Ages: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us?: _____

MEDICAL INFORMATION

Major ailment you want to improve: _____

_____

What brought it on?: _____

What makes it worse?: _____

Does it interfere with your: Daily Routine / Work / Sleep

What have you done for relief?: _____

Medical Diagnoses?: Yes / No X-Rays/MRI?: Yes / No

Are you taking any medications?: Yes / No

Please List/Attach: _____

_____

Describe Exercise/Activities: _____

List Accidents/Operations/ Joint Replacements: _____

_____

List Allergies/Sensitivities: _____

Check the following conditions that apply to you, past and present:

- o Headaches / Migraines
- o Joints: Stiffness / Pain / Spasms / Cramps
- o Bones: Broken / Fractured / Sprained
- o Jaw Pain / TMJ
- o Tendonitis / Bursitis / Arthritis
- o Osteoporosis
- o Spinal Cord Injury
- o Concussion
- o Pregnancy: Current / Previous
- o PMS / Menopause
- o Lymphedema
- o Chronic Fatigue
- o Sleep Disorders
- o Diabetes
- o Fibromyalgia
- o Cancer
- o Heart Condition
- o Stroke
- o Sinus Problems
- o Rashes / Warts
- o Athlete's Foot
- o Indigestion
- o Constipation
- o Intestinal gas / bloating
- o Diverticulitis
- o Irritable Bowel Syndrome
- o Cold Feet or Hands
- o Varicose Veins
- o Hearing Impaired
- o Visually Impaired
- o Depression
- o Drug use
- o Alcohol use
- o Nicotine use
- o Caffeine use
- o Other: _____

_____

MASSAGE INFORMATION *(complete if applicable)*

Have you had a professional massage before? Yes / No

Preferred Pressure: Light / Medium / Deep

Are there any areas you would like to focus on (neck, feet, etc.)?:

Yes / No Please List: _____

Are there any areas you do not want massaged (*face, feet, etc.*)?:

Yes / No Please list: _____

Current Problem Areas: Additional comments:

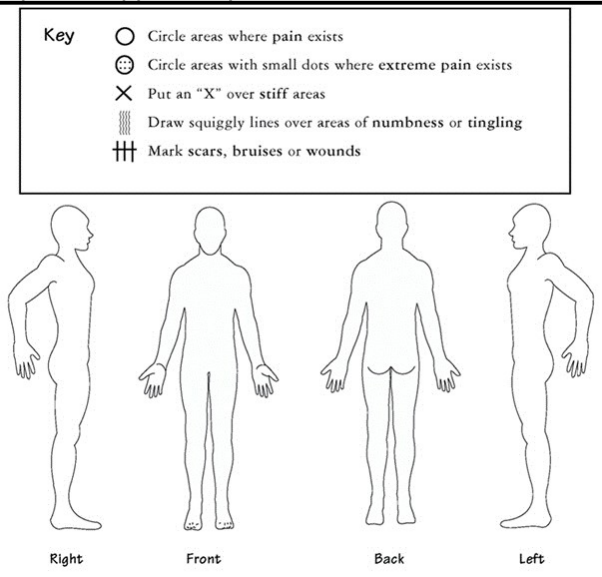
_____

_____

_____

_____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagram to the right:



SKIN CARE INFORMATION *(complete if applicable)*	
Are you under the care of a dermatologist? YES / NO	
Do you use any of the following? Accutane / Retin A / Renova / Adapalene / Resorcinol / Scrub or Peel / N/A Other prescription skin products, please be specific: _____	
Have you had any of the following procedures? Chemical Peel / Microderm / Botox / Dermal Filler / Permanent Cosmetics / N/A Other resurfacing treatments, please be specific: _____ Any serious side effects? YES / NO	
Are you currently using any products that contain the following? Glycolic Acid / Lactic Acid / Hydroxy Acid / Vitamin A / Vitamin C / N/A	
SKIN MAINTENANCE	**Products Used – Brand and Frequency**
Skin Type: Normal / Oily-Congested / Dry-Dehydrated / Sensitive-Redness / Acne / Sunburned	Soap/Cleanser: _____ SPF: _____
Have you been tanning in the last 24 hours? YES / NO	Toner: _____
In the last week have you had: Waxing / Electrolysis	Exfoliator: _____ Masque: _____
What are your skin care goals?	Moisturizer: _____ Other: _____

INFORMED CONCENT

I, _____, (*client*) understand that massage/skin care services provided by Theracopia are intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage/skin care services are specified below:

_____

I understand that massage/skin care services are not a substitute for medical treatment or medications and am aware the practitioner does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of the services.

I have stated all ailments/conditions that I am aware of and this information is true and accurate. I will inform the practitioner of any changes in my status. Should I experience any pain or discomfort during the session, I immediately communicate that to the practitioner so the treatment can be adjusted.

I understand and agree to abide by the following center policies:
Arrival, Reservations and Cancellations; We wish to treat all our clients with respect and in a timely manner and any late arrival may unfortunately deprive you of precious time from your session.

Your services and treatments are reserved and prepared especially for you. Because of our exclusivity and premium services, a strict cancellation policy will be upheld. A 50% fee is charged for cancellation and missed appointments without a minimum notice of 24 hours.

By signing below, you have agreed to the above:

Client Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR

By my signature below, I authorize Theracopia to administer massage/facial techniques to my minor child or dependent as they deem necessary or proper.

_____	_____	_____
Signature of Parent/Guardian	*Contact Phone Number*	*Date*