#### **Patient Information**

Name:			Date of Birth:	
Address:	City:		State:	Zip:
Home Phone:	Cell Phone:		Work Pf	one
E-mail:		Occupation:	121000000000000000000000000000000000000	0.00.000
Emergency Contact Person:		Phone:		
Are you currently under a phys	ician's care for an acute or	r chronic illness? Y	N	
If yes please explain:	ded et 1021 av 111 okan standtet staddsværind			
If yes, who is your health c	are provider:			1.2
Are you currently taking any pr	rescribed medication or dis	etary supplements? Y	C	
If yes, please explain:				
Have you received a massage b	sefore? Y N	If yes, when:		
How did you hear about me? _	Jura 2004 of 100 300 300 02	100000 jana 04550000 iin		
What are your goals for this se-				
Please list areas of tension, stre				
Are you pregnant? Y N				
Please mark an (X) by all curn  Abdominal Aligestive  Diabetes  Fatigue  Headaches, migraine  Hearing problems  Hernia  High blood pressure  Jaw pain/TMJ pain  Low blood pressure  Muscle/bone injuries  Constipation/diarrhea	Depres Rash/fi Sinus Sinus Sloep d Spinal Speain Train Vision Varioo other p Numbe	ssion ungus problems Sifficulties disorders /strain n/stress		Pregnancy problems Allergies Anxiety Artheitis/tendonitis Asthma or lung cond. Athletes foot Blood clots Cheonic pain Circulatory/beart Muscle/joint pain Cancer
Please list any recent injuries	or surgeries within the pa	ast 5 years:		

# **New Spa Client Intake Form Template**

Susan G. Salvo

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