



Massage Intake Form

Glow Health & Vitality New Practice Member

Today's Date *



Month Day Year

Name *

First Name Last Name

Address *

Street Address

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Cell Phone Company

If you choose text reminders

Email *

example@example.com

**I like appt reminders
by: ***

Email
Text

**I like receiving clinic updates
& newsletters: ***

Yes, please!
No, thanks.

Date of Birth *



Month Day Year

Gender *

Occupation

Emergency Contact Name *

Emergency Contact Phone Number *

How did you find out about Glow? *

If a current client referred you, please include their name.

Is this a WCB or MVA claim?

WCB
MVA

Briefly tell us what brought you in today: *

Does this interfere with any of the following?

- Work
- Sleep
- Hobbies/Leisure
- Other

Have you seen another practitioner for this?

Medical doctor, chiropractor, acupuncturist, etc.

How long have you had this?

What makes it better?

Have you had a massage before?

- Yes
- No

If yes, how long ago?

Are you pregnant?

- Yes
- No

If yes, how far along?

Do you exercise?

- Yes
- No

What kind of exercise?

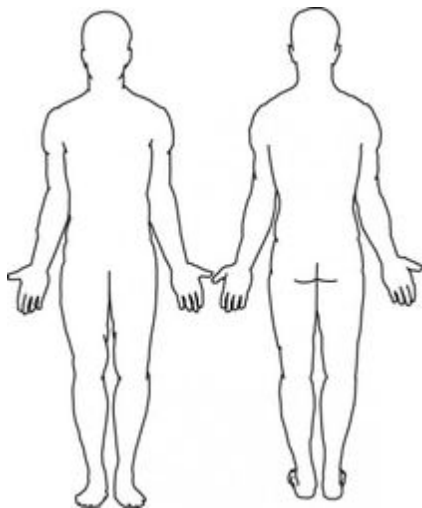
Please rate your stress level:

0 1 2 3 4 5

None

Extreme

Please list all your medications:



Circle area or check box where you're experiencing discomfort: *

- | | | |
|------------|------------|----------|
| Head | Jaw | Neck |
| Shoulders | Chest | Ribs |
| Abdomen | Hips | Thighs |
| Knees | Calves | Ankles |
| Feet | Upper back | Mid back |
| Lower back | Glutes | Arms |
| Elbows | Hands | |

Please select any/all you have had issues with now or ever: *

- | | | |
|-------------------|---------------------|----------------------|
| Asthma | High blood pressure | Skin problems/Eczema |
| Vertigo/dizziness | Cancer | Seizures |
| Migraines | Nerve damage | Diabetes |
| Headaches | Arthritis | Heart disease |
| Varicose veins | Allergies | Digestion issues |
| Surgeries | Stroke | Car accidents |

***Important!* Client must agree to terms: ***

I understand that massage therapy is an aid to health, given for stress reduction, relief from muscle tension, spasm or pain, and/or for increasing circulation. Massage therapists do not diagnose illness or disease and are not a substitute for medical examination or diagnosis. I have stated all my known medical conditions and will update my therapist on any changes.

***Important!* Client must agree to terms: ***

I understand that it is clinic policy to require a credit card on file for all massage clients. If I do not wish to keep a card on file, I agree to prepay for any and all upcoming booked appointments.

I understand that there is a 50% late cancel (under 24hrs)/no show fee for any and all booked appointments, and that my credit card will be charged to cover this cost, and that missed fees are not covered by my insurance provider.

I understand that email, text and voicemail reminders are considered a courtesy provided to me, and that Glow Health & Vitality has no control over reminders that are not received, therefore I am still responsible for any and all fees incurred for any missed appointments in this situation.

Credit Card Authorization & Permission to Keep on File

I authorize Glow Health & Vitality, to keep my signature and current credit card information on file and to charge fees to my credit card account for services provided or for missed or late cancellations. Charges will be made within 48hrs at the fee according to posted services fee schedule. This agreement will be valid until expiration or written cancellation.

By paying via credit card, I acknowledge that the credit card information provided will be automatically kept on file via FOIP (Freedom of Information and Protection of Privacy) and HIPAA (Health Insurance Portability and Accountability Act) compliant encrypted software, and processed by secure and encrypted point of sale.

Credit Card Type	Credit Card Number	Exp.Date	CVC #
Visa			
MasterCard		mm/yy	
American Express			

If I choose not to have my credit card kept on file:

I agree that I must prepay for my appointments upon booking them and I am still responsible for any and all late cancel/no show fees. Charges for services rendered and/or missed fees will be taken from this prepaid amount on my file.

Client Signature

Dated this day of



Month Day Year