

**Pampered Touch Therapeutic Massage, Inc.
Client Information Form**

Name _____ Birth Date _____

E-Mail _____

Address _____ City/State _____

ZIP CODE _____ Home Phone _____ Cell Phone _____

Occupation _____ Other Activities _____

List any serious or chronic illness, operations, chronic virus infections or traumatic accidents you have had:

Are you in recovery for any addictions or abuse? YES NO

If so for what condition(s)? _____

Are you on any medication(s)? _____ If so, what? _____

Do you have any allergies? _____ If so, to what? _____

Are you under a doctor's, chiropractors, or other health practitioner's care? _____

Do I have permission to contact doctors, chiropractors, or other health practitioners? _____

Name _____ Name _____

Phone _____ Phone _____

Why did you come for our service(s)? (relaxation, pain, therapy, etc.) _____

How did you find out about us? _____

If you were referred to our office, who referred you? _____

In case of emergency notify: Name _____ Phone _____

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and in no way take the place of a doctor's care when it is indicated. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is used at my own discretion.

I understand that I am to remain properly draped at all times, no exceptions.

Our time together is precious, and I agree to cancel 24 hours in advance. Unless there is an emergency, **if I miss an appointment, I agree to pay the full appointment fee.**

Signature _____ Date _____