

The Wellness Centre

Confidential Client Intake Form

Name _____ Referred by _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell# _____

E-mail _____

Date of birth _____ Primary care physician _____

Reason for your appointment today? _____

Type of massage experienced? Deep tissue Relaxation Other None

Are you in any pain or discomfort today? Yes No (please describe)

Please read the following and sign below

I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I am also aware there may be some discomfort, soreness, or discoloration that may occur during and/or after today's treatment.

I am responsible for any unpaid balances, deductibles and/or co-pays.

Cancellation Policy

24 hour notice is required to avoid being charged ½ your scheduled massage session.

*Gift Certificates are not redeemable for cash.

*Cannot be returned for for a cash refund. | *Are not valid after the expiration date.

Signature _____ Date _____

Please indicate with an (X) the areas you are feeling discomfort

