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