

In Touch Massage Bodywork & Reiki

Please fill out all information as accurately and thoroughly as possible.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone ( ) \_\_\_\_-\_\_\_\_ Cell Phone ( ) \_\_\_\_-\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Emergency Contact and their relationship to you:  
\_\_\_\_\_ ( ) \_\_\_\_-\_\_\_\_

How did you find out about In Touch? \_\_\_\_\_

Have you ever received massage or bodywork before? (If yes, how was it?)  
\_\_\_\_\_

What (specifically) would you like to receive from this massage?  
\_\_\_\_\_

Would you like me to focus on or stay away from any specific area?  
\_\_\_\_\_

*Health Information:*

Do you have or are you any of the following (Please circle Y=Yes or N=No):

Smoker? Y / N                      Pregnant? Y / N                      Contagious Disease? Y / N

High/Low Blood Pressure? Y / N    Allergies? Y / N                      Heart Conditions? Y / N

Epilepsy? Y / N                      Seizures? Y / N                      Diabetic? Y / N

Frequent Headaches? Y / N            Varicose Veins? Y / N                  Cancer? Y / N

Insomnia? Y/N

Are you currently suffering from any pain related to traumatic experience? (i.e.: Car accidents, sports injuries, surgeries) Y / N

If yes, briefly explain (what and when): \_\_\_\_\_

Are you currently taking any medications or supplements (prescription and non-prescript.) Y / N

If yes, name(s) of medication(s) and how often taken:  
\_\_\_\_\_

Do you have any conditions that may require a doctor's note? Y / N

Is it okay for me to contact your healthcare provider? Y / N If yes, please input info below.

Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_-\_\_\_\_

I attest that the above is true and accurate to the best of my knowledge

Signature \_\_\_\_\_ Date: \_\_\_\_\_