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	Vericose 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: