

TOUCHFITNESS
INFORMATIVE BODYWORK

MASSAGE THERAPY & WELLNESS

MASSAGE INTAKE FORM

CLIENT INFORMATION

To save you time, please print these necessary forms out, fill them out and bring them to your first appointment.

Sherrin Bernstein, LMT
FL Lic.# MA 47391
917-415-6539

140 East 46th St., #6B
New York, NY 10017

1420 Pennsylvania Ave., #407
Miami Beach, FL 33139

touchfitness@mac.com
www.touchfitness.com

1. Name: _____ Date: ____/____/____

Address: _____ Apt: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Fax: _____ Email: _____ Url: _____

2. I prefer to have appointments confirmed at: Home: ____ Work: ____ Cell: ____ Text: ____ Email: ____

3. Date of Birth: ____/____/____

4. Children? Yes: ____ No: ____ Names & Ages (optional) _____

5. Emergency Contact Name: _____ Relation: _____ Phone: _____

6. Physician's Name: _____ Phone: _____ Permission to call? Yes: ____ No: ____

7. How did you hear about TouchFitness? Friend: ____ Ad: ____ Coupon: ____ Web: ____ Other: ____

8. Preferred Pressure: Light: ____ Medium: ____ Deep: ____ Mixed Pressure: ____

9. Prefer: Cold: ____ Heat: ____

10. Preferred Music: Classical: ____ Alternative: ____ New Age: ____ Mix: ____ Other: ____

11. Preferred Options: Oil: ____ Cream: ____ Scented: ____ Unscented: ____ None: ____

12. What kinds of massage have you had? _____

13. Comments/Likes/Dislikes: _____

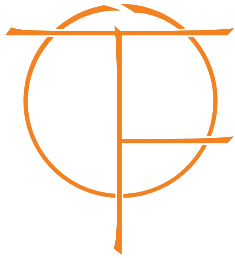
14. Do you have any sensitivities or allergies to essential oils, massage oils or creams? Yes: ____ No: ____

15. What is the primary reason for your visit? _____

16. Please list any secondary considerations or concerns: _____

17. Please list the dates and treatments for any injuries, accidents, surgeries and/or fractures:

CONTINUE TO NEXT PAGE



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18. Please list the physical activities associated with your occupation:

19. List any discomforts you may feel from your occupation:

20. List activity and frequency of exercise or athletic involvement:

21. List any discomforts or injuries you are experiencing from exercise or athletics:

22. Number per day of:

Cigarettes: _____ **Cups of Coffee:** _____ **Glasses of Alcohol:** _____ **Other:** _____

23. Are you pregnant? _____ **Number of months:** _____ **Is this your first pregnancy?** _____

24. Do you have any metal rods, pins, plates, pacemaker surgically implanted in your body? _____

25. If so where? _____

26. Please check off any current conditions and/or any previous conditions:

_____ Asthma	_____ Herpes	_____ Rheumatoid Arthritis
_____ Cancer	_____ Hypertension	_____ Scoliosis
_____ Colitis	_____ Lipomas	_____ Shingles (H. Zoster)
_____ Diabetes	_____ Lyme Disease	_____ Swelling in Joints
_____ Dizziness	_____ Multiple Sclerosis	_____ Tuberculosis
_____ Epilepsy	_____ Osteoporosis/Arthritis	_____ Ulcers
_____ Heart Disease	_____ Psoriasis/Excema	_____ Varicose Veins

27. Please list any medications, supplements, vitamins or herbs you are currently using:

COMPLETE PREVIOUS PAGE