TOUCHFITNESS
INFORMATIVE BODYWORK

MASSAGE THERAPY & WELLNESS

Sherrin Bernstein, LMT
FL Lic.# MA 47391
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140 East 46th St., #6B
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1420 Pennsylvania Ave., #407
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touchfitness@mac.com
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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.

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:

_____

_____

_____

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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:

_____

_____

_____

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