TOUCH FITNESS
informative bodywork

Sherrin Bernstein, LMT
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Information & Appointments:
917-415-6539
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www.TOUCHFITNESS.com

MASSAGE INTAKE FORM

NOTE: To save time, please print these forms, complete them and bring them with you to your first appointment.

1. Name:_____ Date: _____

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

   Home Phone:_____ Work:_____ Cel: _____

   Fax:_____ Email:_____ Website: _____

2. I prefer to have appointments confirmed at: Home:____ Work:____ Cel:____ 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 Touch Fitness? Friend:____ Ad:____ Coupon:____ Web:____ Other: _____

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

9. Prefer: Cold:____ Heat:____

10. Preferred Music: Classical:____ Rock:____ New Age:____ Jazz:____ None:____ 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: _____

    Explain:_____

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

    _____

16. Please list any secondary considerations or concerns: _____

    _____

17. Please list the dates of and treatments for previous injuries, accidents, surguries 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 physical activities associated with your occupation: _____

_____

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

_____

21. List any discomforts or injuries you are experiencing from exercise or athletic involvement: _____

_____

22. Number per day of:

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

23. Are you pregnant?_____ No. of months:_____ First pregnancy?:_____ Due Date: _____

24. Do you have any metal rods, pins, plates or a 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 ❍ Other _____

27. Please list any Medications, Vitamins/Supplements or Herbal Remedies you are currently using:

Medications: _____

Vitamins/Supplements:_____

Herbal Remedies:_____

Your completed form is required for your requested service.