

The Power of Touch Massage & Wellness



Intake Form

Name _____ Date _____

Address _____

Day time Phone _____ Date of Birth _____

Email _____

Profession / Work Environment _____

How did you hear about me? _____

Have you received a massage/bodywork before? Yes / No

Type/Style _____

Are you currently under medical treatment that I need to know about?

Yes / No - If yes, for what condition? _____

Please list your doctor's name and phone number: (Optional)

Are you taking any medication or do you have any allergies I need to be aware of?

If so, please list:

Miguel A. Solis, Jr.

Certified Massage Therapist, CMTTC# 34736

The Power of Touch Massage and Wellness

Email: Miguel@ThePowerofTouch.biz

www.ThePowerofTouch.biz

Phone: (760) 413-7847

If you are currently experiencing or have experienced any of the following conditions, please check:

___ Arthritis

___ Diabetes

___ Sciatica

___ Respiratory/Lungs

___ Scoliosis

___ Varicose Veins

___ Cardiovascular/heart

___ Indigestion

___ Skin Problems

___ Weakness

___ Headaches

___ Numbness

___ High/Low blood pressure

Other (includes injuries, sore spots, major illness, surgery, etc)

Are you involved in a regular exercise program? Yes/No If yes, what and how often

What is your goal/intention for today's massage? Any areas of your body I should pay special attention to?

Any Information I should know about your health/condition today?

Signature _____

Date _____

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