



ALETHEIA
.... RELAXATION CENTER

MARCUS MUNRO LMP
Massage Intake Form

(Please Print)

Client name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone numbers (c) _____ (h) _____ (w) _____

Email: _____ (appt reminders are by email)

Occupation: _____ Date of Birth: _____

Marital Status: *Married Single Separated* **Employment Status:** *Employed Unemployed Student*

How did you hear about my massage practice?: _____

Please check all that apply:

headaches neck pain back pain jaw clenching/teeth grinding leg/knee pain seizures bruise easily
wear contacts allergies varicose veins high blood pressure numbness/tingling active cancer? _____ chemo/radiation? _____ If yes ONCOLOGY REPORT REQUIRED

accidents/injuries/surgeries in the last 2 years? _____ pregnant (how many weeks?) _____ trying to get pregnant? _____ postpartum 2 years or less? _____

do you have any allergies and/or skin sensitivities? _____

any medical issues you would like us to know about? _____

are you taking any medications? Yes No If yes please list _____

If we are billing your insurance, please list insurance information below:

Auto/Medical Insurance Carrier: _____ Claim/ID&Group #: _____

Claim Rep Name: _____ Claim Reps Phone/Medical Ins #: _____

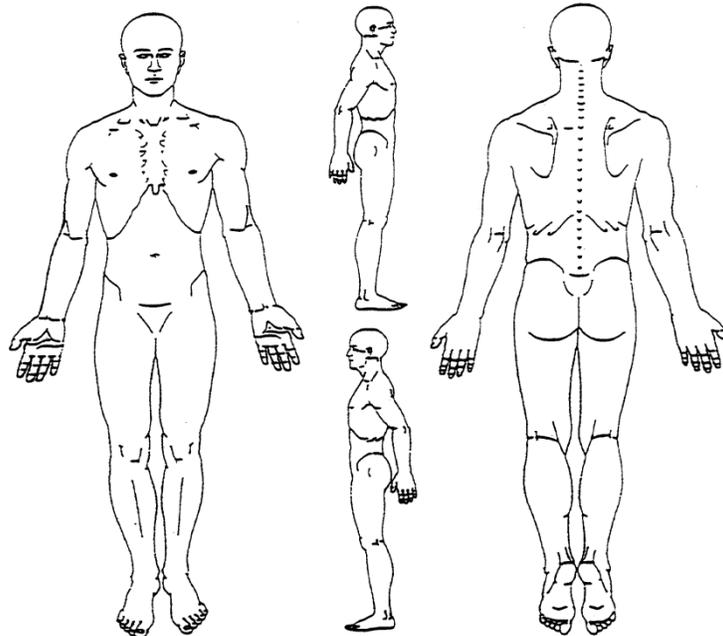
Personal Injury Protection Available? YES NO Date of Injury: _____

***As a courtesy to you, we will bill your insurance for you. It is important for you to note that if your insurance company does not pay, FOR ANY REASON, within 60 days of billing, the balance of the account becomes your responsibility. The insurance agreement is between you and your insurance company, not between the insurance company and the practitioner. Our fees generally fall within the acceptable range by most companies; therefore, they are covered up to the maximum allowance determined by each carrier as usual, customary and reasonable fees for our region.

By signing below (please check all):

- I understand that massage is not a replacement for medical care and that no medical diagnosis will be made.
- I understand that any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session.
- CANCELLATION policy: I am responsible for full session fee if I cancel an appointment with less than 24 hours notice.**
- I understand that if my insurance company denies payment for my services for any reason, I am responsible for the balance on my account.

Signature: _____ Date: _____



X Adhesions	@Tender Point	★ Inflammation	/// Numbness
!!!Pain	~~~~Spasm	△ Burning	○ Tingling
Other notes:			