Intake Form

Please print clearly

Name_____ Sex_____ Height_____ Weight_____

Phone # 1_____Cell, H, W # 2_____Cell, H, W

Address_____ City_____ St_____ Zip_____

Email address: _____ Occupation:_____

Date of Birth – M_____D_____Y_____ Place of Birth_____

Living Status: Coupled_____Uncoupled_____Number of Children living with you_____boys_____girls

Please check if any of the following apply to you:

_____allergy to nut oils _____high blood pressure _____skin conditions

_____blood clots _____low blood pressure _____surgery in last year

_____diabetes _____pregnant _____varicose veins

_____heart attack/stroke _____serious injury _____headaches

Please list any medications you are currently taking and what they are for:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Contact in case of emergency: Name_____ Phone #_____

Policies

There is a $15 fee for all cancellations given without a 24-hour notice.
There is a $15 service charge for all bounced checks.

I have read and understand the above conditions _____ _____
Signature Date