WINNING YOUR WELLNESS BACK

Therapeutic Massage

P.O. Box 634; Mesa, AZ 85211

Rebecca L.S. Winn NLMT, NCBTMB

CLIENT INTAKE FORM

DATE: _____ BIRTH DATE: _____.

NAME: _____ SEX: _ _ _ MALE _ _ _ F EMALE

ADDRESS: _____ CITY: _____ STATE: ZIP: _____.

HOUSE #: ( ) DAY _ _ _ NIGHT _ _ _ WORK #: ( ) DAY _ _ _ NIGHT _ _ _

MOBILE #: ( ) DAY _ _ _ NIGHT _ _ _ OTHER #: ( ) DAY _ _ _ NIGHT _ _ _

SOCIAL SECURITY NUMBER: _____. DRIVER LICENSE #: _____.

MARITAL STATUS: _ _ _ SINGLE _ _ _ MARRIED _ _ _ DIVORCED _ _ _ WIDOWED

SPOUSE 'S NAME: _____.

CHILDREN 'S NAMES/ AGES: _____.

PREFERRED APPOINTMENT DAY/TIME: _____.

EMPLOYER: _____ OCCUPATION: _____.

EMPLOYER ADDRESS: _____.

PRIMARY CARE PROVIDER: _____.

PROVIDER 'S ADDRESS: _____.

PHONE: _____ EXTENSION: _____.

PERMISSION TO CONSULT WITH PRIMIARY PROVIDER? _ _ _ NO _ _ _ YES (INITIAL IF YES): _____.

INSURANCE CARRIER: _____ POLICY #: _____.

ID #: _____ GROUP #: _____ CLAIM #: _____.

ADJUSTER 'S NAME: _____.

ADJUSTER 'S ADDRESS: _____.

PHONE: _____ EXTENSION; _____.

TIME AND DATE OF INSURANCE VERIFICATION: _____.

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: _____ **PHONE:** _____.

RELATIONSHIP: _____.