



Client Information and Policy Form

Client Information

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME#: _____ CELL#: _____
EMAIL: _____
DATE of BIRTH: _____ OCCUPATION: _____
How did you hear about us? _____
Who referred you? _____

Emergency Contact Info

NAME: _____
PHONE#: _____ RELATIONSHIP: _____

Health History - Please circle all that apply:

Scoliosis Sciatica Glaucoma Fused disks Herniated disks
Osteoporosis Back surgery Asthma Arthritis Plantar Fascitis
Migraines Chronic Illness Hi/low blood pressure Low Flexibility Knee/Hip/Shoulder
Any surgery in last 12 months (*requires letter of consent from physician*): _____

Other Ailments: _____

Are you pregnant or planning a pregnancy? _____ How many weeks? _____
High Risk pregnancy? (*requires letter of consent from physician*)? _____

Studio Booking and Payment Policies

- I understand that all appointments are subject to a 24-hour cancellation policy and that if I fail to cancel within 24 hours I will be charged the full amount.
- There is a \$35 fee for all returned and/or bounced checks.

SIGNATURE: _____

DATE: _____