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 (*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 my account will be charged the full amount.

~ There are no refunds or transfers of packages.

~ There is a $35 fee for all returned and/or bounced checks.

SIGNATURE:_____

DATE:_____