Capital Medical Group

---CAPITAL AESTHETICS

MASSAGE THERAPY SERVICE INTAKE FORM

Name:_____ Today's Date: _____
Address:_____ Birth Date: _____
City_____State_____ Zip_____ Male_____Female_____
Phone:_____ other: cell:_____ email address:_____
Occupation:_____
Emergency Contact:_____ and his/her phone#:_____

How did you hear about us?_____ Is this your first professional massage? ___
Please comment on any of the following that apply to your health:
Do you wear contact lenses?_____ glasses?_____
Injuries/Accidents:_____
Chronic illness: _____
Current medications? _____
Chronic Pain? _____ Where?_____
Where in your body do you feel the effects of stress?_____

Please check any conditions you are currently experiencing:
_____ Pregnancy _____Flu or Cold _____Infection _____Inflammation
_____Fever _____Contagious Disease _____Anemia _____Allergies ___Rash
_____Sores _____Bruise Easily _____Sensitivity or lack of (where?)_____
_____Athletes Foot _____High Blood Pressure _____Varicose Veins
_____Shortness of Breath or other breathing problems. Other skin conditions: _____

Is there anything you feel we should know about that would help us provide your best result? Sports program participation? Frequent body positions or repetitive movements?

_____

_____

_____

_____

_____

AGREEMENT: I have completed this form to the best of my knowledge. I understand that Massage Therapy is not a substitute for medical examination and diagnosis, and that it is recommended that I see a primary health care provider for those services. Any information exchanged during a Massage Therapy session is confidential and is only used to provide the best health services.

Client Signature: _____ Date:_____

Therapist:_____ Date:_____

Capital Medical Group --- Capital Aesthetics
1001 Leawood Drive Suite A ◊ Frankfort, KY 40601 ◊ ph: 502.875.0872 fax: 502875.2387

FINANCIAL POLICY

Payment for Aesthetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Cancellations must be made 24 hours in advance of your appointment time. No shows or cancellations with less than 24 hours notice may result in a $25 charge.

Please expect to pay in full for the service on the day it is performed.

We accept

CASH

CHECKS

Most Major Credit Cards: Visa, Master Card, American Express, Discover

CareCredit: no interest and extended payment plans subject to credit approval.

I acknowledge that I have read the financial policy above and understand that I am responsible for payment for my services at the time of service.

_____ Date:_____