

Adrien Daniel, LMT - CranioSacral Therapy & Massage

Phone: 832.746.2902 (cellular phone with voice mail)

Location: 2502 Huldy, Houston, TX 77019 (near Westheimer / S. Shepherd)

Intake Form

(Please Print and Bring to Appointment)

Name: _____ Date of Birth: _____

If under 18 years old, please print the Parent's Name who accompanies: _____

Email Address: _____ Daytime #: _____

Mailing Address: _____ Mobile #: _____

Service(s) you are requesting today: _____ Craniosacral, _____ Relaxation, _____ Deep Tissue, _____ Consultation Only

Physical Area(s) experiencing discomfort: _____

Other discomforts? (circle): Lack of Sleep, Lack of Concentration, Frequent Illness, Frequent Headaches, Dizziness, Fatigue, Family Issues, Work Issues, Burnout, Changes in Digestion/Elimination, New Allergies, and/or others (use back of the form).

Have you seen at least one practitioner who has prescribe medicine for any of the above discomforts and/or other distresses or diseases? _____ If so, list your current medications: _____

List any Supplements or Natural cures currently in use: _____

On average, what is your daily intake of... Pure Water _____ oz., Deep Breathing _____ mins., TV time _____ mins.,

Computer Time _____ mins., Stretching _____ mins., Walking _____ mins., Relax time _____ mins., Meals and Snacks _____

Other information you wish to share can be listed on the back of this form.

List Area(s) to Avoid: _____ (inform Adrien if these ever change)

OFFICE POLICY

- Adrien adheres to the State laws as they are defined for Licensed Massage Therapists.
- Any discomfort (physical or otherwise) must be reported to Adrien immediate during the session.
- This signed form is your documented permission allowing Adrien to proceed with your requested treatment.
- Adrien does not sell any client's personal information, including mail and email addresses.
- If Adrien is taken ill or is unable to provide services, she will contact you as soon as she is aware of the situation.

PAYMENT and CANCELLATION POLICY (With regret, this has become necessary, SO PLEASE READ THIS CAREFULLY.)

Payment for treatment is due at each session unless payment arrangements are discussed with Adrien during appointment scheduling. If cancellation is necessary, please notify Adrien 24 hours in advance or incur a \$50 fee. If this policy is not observed, an invoice will be mailed to your address as provided above. If a **medical emergency of self or dependant** prevents you from keeping your appointment, inform Adrien, within 24 hours after your missed appointment to avoid incurring the \$50 fee.

Adrien's cell phone has voice mail and your message will be received there as well as your phone number ID. Personal checks are accepted for payment, however, if your check is not honored by your bank, a returned check fee of \$50 is incurred without exception. If payment arrangements are needed, please talk with Adrien during your appointment scheduling.

Client Signature: _____ Print Name and Date: _____

In case of emergency, please list a contact: _____ Relationship: _____ Phone(s): _____