SALON CLIENT INTAKE FORM

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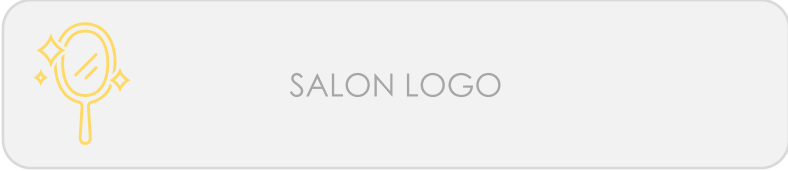

DATE	TENDING STAFF MEMBER

CLIENT INFORMATION

NAME		ADDRESS	
PRONOUNS			
DATE OF BIRTH			
HOME PHONE			
ALT. PHONE			
EMAIL			

Specify areas you would like us to target.

Please circle any of the following conditions you've had a health issue with.

arthritis			broken bone		
anemia	bladder trouble	poor circulation	measles	____________	____________
cancer	chest pain	sinus trouble	hepatitis	____________	____________
convulsions	high blood pressure	asthma	tuberculosis	____________	____________
seizures		indigestion	neck pain	____________	____________
migraines	kidney trouble	dermatitis	diabetes	____________	____________
osteoporosis	heart trouble	epilepsy	artificial joints		

Please elaborate on any conditions circled above.

PAYMENT INFORMATION

PAYMENT TO		PAYMENT DATE	
RECEIPT NUMBER		AMOUNT PAID	
PAYMENT METHOD			
RECEIVED FROM		RECEIVED BY	

ACCOUNT INFO			**PAYMENT PERIOD**	
ACCT BALANCE	THIS PAYMENT	BALANCE DUE	FROM	
			THROUGH	
PAYMENT FOR			**ADDITIONAL INFO**	

INSURANCE INFORMATION

NAME OF CARRIER		INSURED'S DATE OF BIRTH	
NAME OF INSURED		GROUP NUMBER	
SUBSCRIBER ID		SIGNATURE	

SALON LOGO

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