



COPPER TREE RETREAT
MASSAGE • MED SPA

Welcome to Copper Tree Retreat Med Spa

Please help us to serve you by completing our Client Information Form

Date ____/____/____
Month Day Year

Salutation (Please Indicate One) Mr. / Mrs. / Ms. / Miss / Dr.

First Name _____ Last Name _____

Gender _____ Date of Birth ____ / ____ / ____ Anniversary ____ / ____ / ____

Driver's License #: _____

Mobil (____) ____ - ____ Yes / No I wish to receive Copper Tree Retreat Reminders via Text

Home (____) ____ - ____ Yes / No I wish to receive Copper Tree Retreat Reminders via E - Mail

Work (____) ____ - ____

Occupation _____ Place of Employment _____

Whom may we thank for referring you? _____

E- Mail Address _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip _____

Significant Others Name _____ DOB ____ / ____ / ____ Phone (____) ____ - ____

Emergency Contact _____ Phone (____) ____ - ____

Primary Care Provider _____ Phone (____) ____ - ____

Children (Minors) _____

Do you have a gender prefer for your Massage Therapist Yes ____ No ____

If yes do you prefer a _____ Male Therapist or _____ Female Therapist

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