BODYOGRAPHY
Wellness Center

Office Use Only:

fc:

rb:

Client Intake Form

Name:_____ Today's Date:_____
Address:_____ Home Phone:_____
City, State, Zip Code:_____ Cell Phone:_____
Email address:_____ Work Phone:_____
DOB:_____ Occupation:_____ Height:_____ Weight:_____
Email? Yes No US Mail? Yes No How did you hear about us?_____

In case of emergency, please notify:
Name:_____ Relation:_____ Phone:_____

Current Condition/Medical History:

Have you ever received massage or other bodywork therapy before? Yes No
If yes, what type?_____ How often?_____

What are your goals for receiving regular massage?_____

Please rate the stress level in your life (5 is the most) 1 2 3 4 5

Please list all of your major complaints: **Date of onset:**

_____ _____
_____ _____
_____ _____

Are you currently under the care of a medical doctor/health practitioner? Yes No
If yes, for what condition?_____
Health practitioner's name & phone number:_____
Please list all the medications /supplements you currently take, including dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list any accidents/surgeries you have had: **Date:**

_____ _____
_____ _____
_____ _____

Have you had orthodontic work? Yes No **Dentures?** Yes No
Do you wear contact lenses? Yes No **Do you smoke?** Yes No
Do you exercise? Please describe:_____
_____

(please turn over)

Please check if you have/had any of the following:

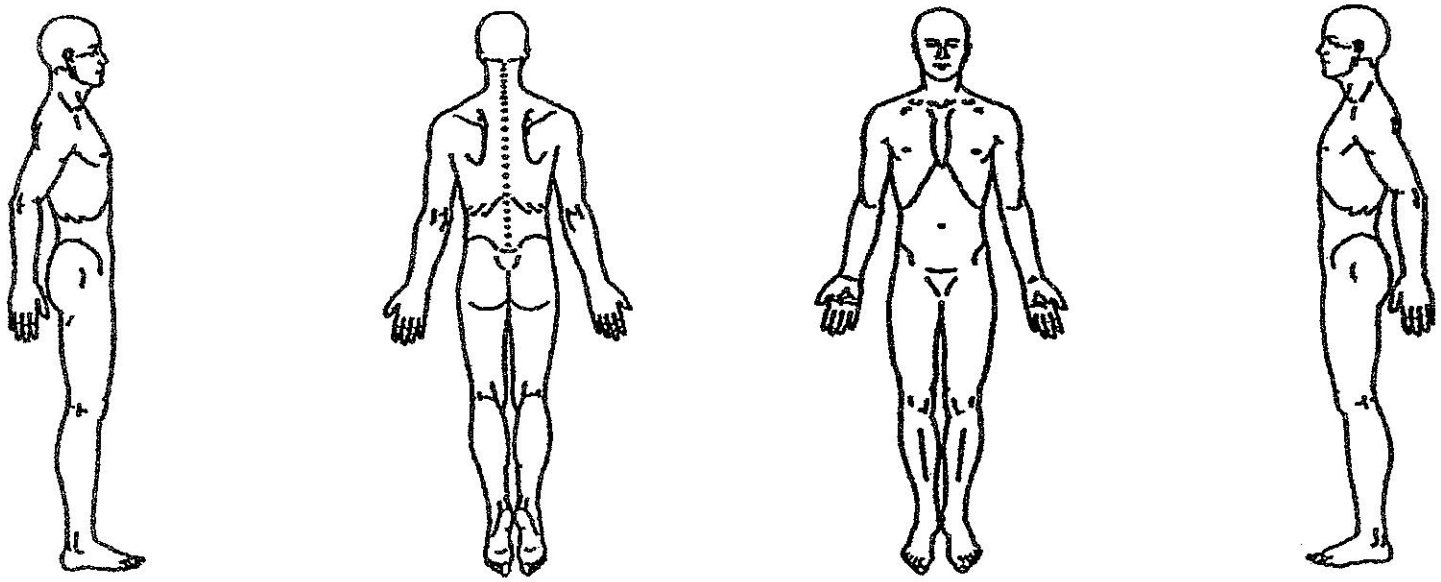
___Allergies	___Arthritis	___Asthma	___Back pain
___Bursitis	___Cancer	___Car accident	___Carpal Tunnel
___Chest pains	___Circulatory problems	___Dislocations	___Decreased range of motion
___Diabetes	___Digestive disorders	___Dizziness	___Edema
___Fatigue	___Fibromyalgia	___Fractures	___Fainting spells
___Gout	___Headaches	___Heart conditions	___Herniated discs
___HIV/AIDS	___Insomnia	___Loss of balance	___Low/High blood pressure
___Muscle sprain	___Neck pain	___Nerve damage	___Pins/needles
___Pacemaker	___Pregnant now	___Respiratory problems	___Sciatica
___Seizures	___Shortness of breath	___Sinusitis	___Skin problems
___Spinal disorders	___Sport injury	___Stress	___Surgeries
___Tendonitis	___TMJ	___Ulcers	___Varicose veins

Any other medical conditions:_____

_____

_____

Please indicate any areas of joint or muscle pain on the figures below:



Waiver/Informed Consent:

I, _____, understand that the massage therapy provided by Bodyography Wellness Center, LLC is intended to enhance relaxation, release muscle tension or spasm, increase range of motion, or improve circulation or energy flow. I understand the massage therapist does not diagnose illness or disease, does not prescribe medications, and does not perform spinal manipulations. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended I see a physician for any ailment I may have. I have informed the massage therapist of all my known physical conditions, medical conditions, and medications. I will keep the massage therapist updated on any changes. In situations where a physician's medical release is requested by Bodyography Wellness Center, LLC and the client refuses and/or is unable to provide it, the client shall take full responsibility for any loss, injury, or damages. **Twenty-four (24) hour notice of cancellation is required or I agree to pay the full cost of the session scheduled.**

Signature:_____ Print Name:_____

Therapist Signature:_____ Date:_____