INTAKE AND RELEASE FORM

BODY THERAPEUTICS
2500 Broadway #E
Grand Junction, CO 81507

Today's Date:

Name:			
Address:			
Email:			
Phone:			
Date of Birth:	Height:	Weight:	Occupation:
Emergency Contact (Name):			(Phone):

How did you hear about us?

Are you under the care of a physician, or have any diagnosed conditions?_____(if yes, please explain)

_____

Please list any medications you are now taking _____

Please list any surgeries, major illnesses, injuries or accidents you have had _____

_____

Are you Pregnant? _____ If yes, how far along _____ weeks.

Do you have any hearing, sight, or speech problems? _____

Are you allergic to essential oils? _____ If Yes, describe _____

Please Mark if Yes, Check this Box if No to All ☐	
Cancer and/or Tumors (past or present)	Back or Spinal Problems
Blood Clots	Bone or Joint Problems
Phlebitis	Arthritis
Heart Problems	Numbness or Tingling
Renal Failure	Skin infections, lesions, rashes, sores, warts
High Blood Pressure	Athletes Foot
Bruises, Varicose or Spider Veins	Asthma (Inhaler?)
Diabetes or Kidney Problems	Pacemaker
Dialysis	Seizures or Convulsions
Depression	Epilepsy
Headaches or Migraines	Rapid Weight Loss (Recently)
Insomnia	Cold or Flu (Currently)
Sinus Problems	Hepatitis A, B or C (Please circle)
Allergies or Allergy Symptoms	MRSA or Staph Infection
Sciatica	Tuberculosis
Inflammation	HIV/AIDS
Chemical Sensitivities	Other Contagious or Chronic Infections or Disease (Please List)

Please indicate for each of the following if you have experienced one of the following codes:
<u>Codes:</u> 1 for Never Had, 2 for Previously Had, 3 for Currently Have

___ Neck Problems
___ Arm Problems
___ Pain between Shoulders
___ Low Back Problems
___ Leg Problems
___ Swollen Joints
___ Painful Joints
___ Sore Muscles
___ Weak Muscles
___ Walking Problems
___ Ruptures of Tendons
___ Broken Bones

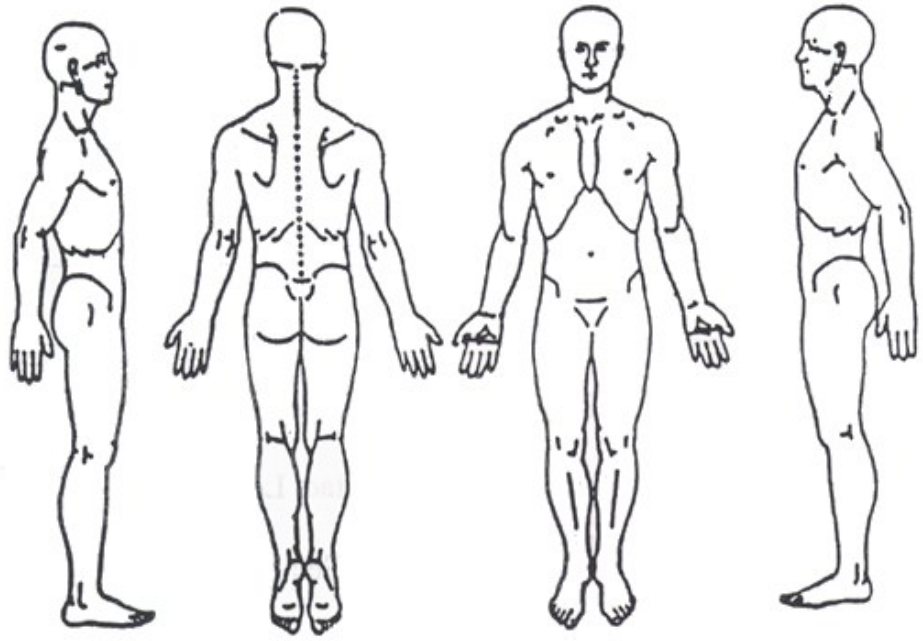
___ Numbness
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle Jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

___ Chest Pain
___ Heart Pain
___ Rapid Heart Beat
___ Heart Problems
___ Difficult Breathing
___ Persistent Cough
___ Coughing up Phlegm
___ Coughing up Blood
___ Lung Problems

<u>Massage Information</u>

Have you had a massage before? _____ If yes, what type(s) _____

Please indicate the location and sensation of your body pain using the following symbols:
^^^^ Numbness **xxxx Burning** **//// Stabbing/Sharp** **oooo Pins & Needles**
****** Aching/Dull** **EEEE Electrical**



Please Initial the following:

_____ I am not under the influence of drugs or alcohol.
_____ I understand that failure to disclose a current communicable illness or if I am under the influence of any substance may result in my session being terminated or that I may denied service by Body TMM.

By signing the form below you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.
Client Signature _____ Date _____