Natural Herbal Body Solutions

Bodywork Intake Form

Welcome! We would like for you to take time to answer a few questions so that we can better serve your needs. Please let us know if you have any questions.

Occupation _____
Name_____Date of Birth_____
Address_____
City_____ State_____ Zip code_____
Phone (H) _____ (CP) _____
Email Address: _____
Emergency Contact:_____Relationship_____

May we send you: Reminders _____ Specials_____ **via:** Email _____ Text/SMS_____
How did you hear about us? _____
Have you had any recent accidents or injuries? _____
Are you currently seeing a healthcare professional for any current or ongoing treatment?
No /Yes If yes, please list reason for treatment_____
Are you currently taking any medications? ___If yes, please list name and reason for medications:
_____
_____
_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___autoimmune condition*
___hepatitis (A,B,C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
___depression, panic disorder, other psychological conditions
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___chemical dependency

(*AIDS, Fibromyalgia, chronic fatigue, lupus, etc.)
If any of the above needs to be detailed or if there is anything else to share, please do so:
_____
_____
_____
_____
.

Natural Herbal Body Solutions

Clients Name: _____

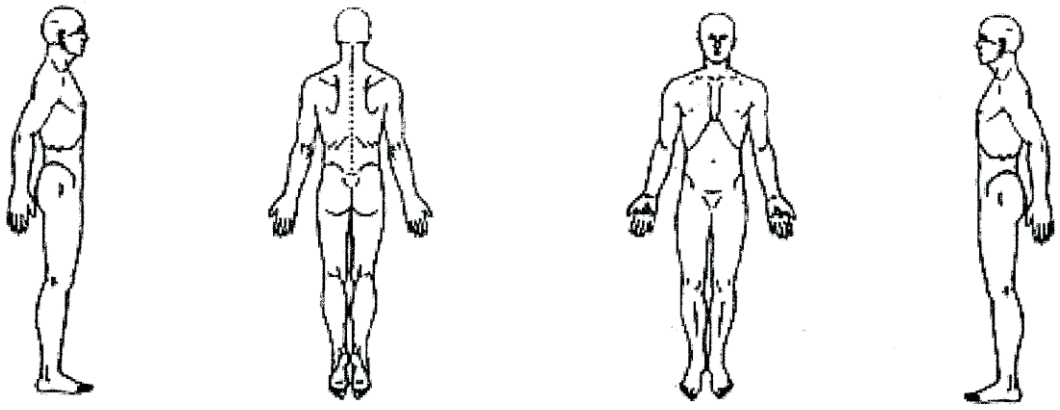
Do you have any of the following today:
skin rash ____cold/flu _____ open cuts _____ severe pain _____ injuries/bruises _____ anything contagious_____

Do you have any allergies to?
medications ____ foods (nuts, etc.) ___-_ environmental allergens (dust, pollen fragrances)_____
reactions to skin care products, topical creams/oils, or essential oils_____

If any of the above are checked, please give details:
_____
_____
_____

Are you wearing: ___ contact lenses ___ hearing aid ____ hair piece_____

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this session? _____
The following sometimes occurs during a session. They are normal responses to relaxation. Trust your body to express what it needs to can include: need to move or change position; sighing, yawning, change in breathing; stomach gurgling; emotional feelings and/or expression movement of intestinal gas; energy shifts; falling asleep and memories.

Please read the following information and sign below:

1. I understand that although a session can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. This is a therapeutic session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

3. Being that a session should not be done under certain medical conditions, I affirm that, I have answered all questions pertaining to medical conditions truthfully.

_____ _____
Signature Date