

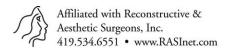
BODY THERAPIES MLD INTAKE FORM

Name:	DOB:_	Age:	Gender:
Address:	City:	State:	Zip Code:
Home Phone:	Cell:	Work	::
Email Address: (Your email address will be used for appointment)	nt confirmations, quarterly 1	Occupation:newsletters, and to alert you of	specials and promotions.)
How were you <u>originally</u> referred to Bel Dr. Colville Dr. Zavell Dr. Khan Other:	n Website	Friend:	
	MEDICAL HIS	STORY	
Please check any of the following condi-	tions that apply to you:		
FibromyalgiaHepatitisImmune Deficiency DiseaseMigraine HeadachesSciaticaTMJ Do you have circulation problems or do Do you have any allergies to lotions/oils	s, seaweed/iodine, or n	Care Ecches Head Pressure Information Lyaman Lyaman Lyaman Lyaman Lyaman Lyaman Va	
Have you ever had a stroke or any other	major injury? If yes, p	lease explain:	
List all surgeries you have had within the	e last five years along w	rith the dates of the surge:	ries:
Name and location of your surgeon(s):_ List any medications, herbals, and vitam	ins that you are current	tly taking:	
Do you have any other medical condition explain:			about? If yes, please
Have you had any lymph nodes remove	d? if yes, please explain	where:	

BODY SPECIFICS

What are your expectations of the body treatment you will receive today?			
Where are your specific areas of complaint, pain or ter	nsion?		
	usis?		
If yes, do you receive massages on a regular ba Are you especially sensitive to touch/pressure in any s	specific areas?		
By signing below, I agree to the following statement:			
	I for the basic purpose of stress reduction, relief from , lymph, and energy circulation. I have stated all known ist updated on any changes regarding my health. I claim full		
**************************************	*********************		
Signature:	Date:		

Thank you for visiting Bella Via!



Craig W. Colville, M.D., F.A.C.S. John F. Zavell, M.D., F.A.C.S.