

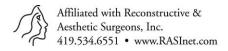
## BODY THERAPIES MLD INTAKE FORM

Name:	DOB:	Age:	Gender:
Address:	City:	State:	Zip Code:
Home Phone:	_ Cell:	Work:	
Email Address:(Your email address will be used for appointment of	confirmations, quarterly newslette	Occupation:	specials and promotions.)
How were you <u>originally</u> referred to Bella Dr. Colville Dr. Zavell Other:	Website	* * '	
Please check any of the following condition	MEDICAL HISTORY	<u>Y</u>	
Arthritis/RheumatismBlood ClotsCarpal Tunnel SyndromeFibromyalgiaHepatitisImmune Deficiency Disease	AsthmaBursitisDiabetesFrequent HeadachesHigh/Low Blood PressJoint ProblemsNail/Foot FungusSeasonal AllergiesTorn Rotator Cuff  ou bruise easily?	Car Ecz Hea Sure Info Cyr Op Thy	ck Pain ncer: type zema/Psoriasis art Problems ectious Disease nph Node Removal en Wounds/Infections yroid Condition nicose Veins
Have you ever had a stroke or any other n	najor injury? If yes, please ex	xplain:	
List all surgeries you have had within the l	ast five years along with the	dates of the surger	ies:
Name and location of your surgeon(s): List any medications, herbals, and vitamin	s that you are currently takin	ng:	
Do you have any other medical condition explain:	· ·	rapist should know	about? If yes, please
Have you had any lymph nodes removed?	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 tension?
Have you had a professional massage before?  If yes, when?  If yes, do you receive massages on a regular basis?  Are you especially sensitive to touch/pressure in any specific areas?
By signing below, I agree to the following statement:
I understand that my body therapy session is provided for the basic purpose of stress reduction, relief from muscular discomfort, and for help in increasing blood, lymph, and energy circulation. I have stated all known medical conditions and I will keep the massage therapist updated on any changes regarding my health. I claim full responsibility for services rendered.
I consent to having "Before" and "After" photographs of said procedure(s) for the purpose of documentation in my file. These photographs may or may not (please initial one) be used anonymously on our website or in our brochure for advertising purposes.
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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.