BODY THERAPIES MLD INTAKE FORM

Name:____ DOB:______________ Age:________ Gender:____________

Address:______________________________________ City:_______________ State:________ Zip Code:__________

Home Phone:________________________ Cell:____________________________ Work: ______________________

Email Address:____Occupation: ___________________________

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)

Dr. Colville Dr. Zavell Website Friend: ________________________________

Other: ____

MEDICAL HISTORY

Please check any of the following conditions that apply to you:

______Arthritis/Rheumatism	______Asthma	______Back Pain
______Blood Clots	______Bursitis	______Cancer: type______________
______Carpal Tunnel Syndrome	______Diabetes	______Eczema/Psoriasis
______Fibromyalgia	______Frequent Headaches	______Heart Problems
______Hepatitis	______High/Low Blood Pressure	______Infectious Disease
______Immune Deficiency Disease	______Joint Problems	______Lymph Node Removal
______Migraine Headaches	______Nail/Foot Fungus	______Open Wounds/Infections
______Sciatica	______Seasonal Allergies	______Thyroid Condition
______TMJ	______Torn Rotator Cuff	______Varicose Veins

Do you have circulation problems or do you bruise easily? ___________________________________

Do you have any allergies to lotions/oils, seaweed/iodine, or medications? ________________________

____

Have you ever had a stroke or any other major injury? If yes, please explain: ______________________

____

List all surgeries you have had within the last five years along with the dates of the surgeries: ____________

____

Name and location of your surgeon(s):____

List any medications, herbals, and vitamins that you are currently taking: __________________________

____

Do you have any other medical condition(s) that your technician/therapist should know about? If yes, please explain: ____

____

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!

Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
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