BELLA VIA
Skin and Body Therapies

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 Dr. Khan 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.

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Signature:_____ Date:_____

Thank you for visiting Bella Via!

Affiliated with Reconstructive &
Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

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