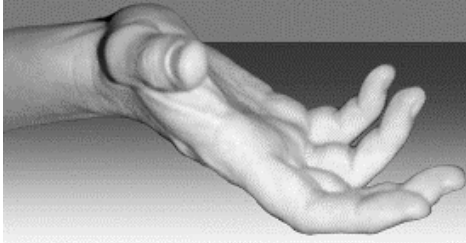


CRANIOSACRAL - NEUROMUSCULAR - REFLEXOLOGY - MASSAGE

BODY WISE

HEALTH CENTER AND SPA



CHERI GILLHAM
706 E. BLANCO ~ BOERNE
(830) 743-1310
(830) 249-8599

BODYWISECHERI@YAHOO.COM

Confidential Client Intake Form

Name:

Date of Birth:

Street / Mailing Address:

City:

State:

Zip:

Home Phone: ()

Cell Phone: ()

Work Phone: ()

Occupation:

Home email address:

Would you like be to added to email? Y/N:

Referred By

Emergency Contact:

Treatment time is valuable to all clients, so if you cannot keep your scheduled appointment, please call to reschedule so that someone else can utilize your appointment time.

**I hold your appointment just for you.
A "No Show" will be billed to you for the missed session.**

Please check any of the symptoms or physical problems you are currently or have previously experienced:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches / Sinus | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Migraines | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Whiplash |

www.BodyWiseHealthCenter.com

BodyWiseCheri@yahoo.com

General & Medical Information:

YES NO

- ____ ____ Do you see a Chiropractic Doctor? If so, whom? _____
- ____ ____ Are you currently under any Doctor's care? If so, whom? _____
- ____ ____ Have you ever had massage/bodywork? If so, how long ago? _____
- ____ ____ List any previous / current broken bones _____
- ____ ____ Have you had any traumatic accidents _____
- ____ ____ Have you ever had surgery? When _____
- ____ ____ Do you have tension or soreness in a specific area _____
- ____ ____ Do you have numbness, or stabbing pains anywhere? _____
- ____ ____ Are you very sensitive to touch/pressure in any area _____
- ____ ____ Do you have cardiac or circulatory problems? _____
- ____ ____ Are you wearing contact lenses? If so, hard or soft? (Circle one)
- ____ ____ Are you allergic to: Lanolin, analgesic balms, other? (Circle one)
- ____ ____ Do you prefer a cool, warm or very warm treatment room? (Circle one)
- ____ ____ Do you have any other medical conditions that I should be aware of? _____

Please list all medications you are taking:

Please take a moment and carefully read the following information and sign where indicated.

I (the client) understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a allopathic physician, chiropractic physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I further understand that bodyworkers / massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

I understand everything discussed during the treatment will be held in total confidentiality between the practitioner and myself.

Signed: _____

Date: _____

Practitioner: _____

Date: _____