INTAKE AND RELEASE FORM

BODY THERAPEUTICS MEDICAL MASSAGE
514 28 1/4 Rd. Ste#4, Grand Junction, CO 81501

Name:	Today's Date:
Address: Email:	Your Primary Medical Practitioner Name: Phone: Address:
Phone:	Emergency Contact: Phone:
Date of Birth: Height: Weight: Occupation:	

How did you hear about us?_____

Have you had massage before?_____If yes, describe_____

Are you under the care of a physician, or have any diagnosed conditions?_____(If yes, please explain)

_____

Please list any medications you are now taking_____

Please list any surgeries, major illnesses, injuries or accidents you have had _____

_____

Are you Pregnant?_____ If yes, how far along _____ months.

Do you have any hearing, sight, or speech problems? _____

Are you allergic to essential oils?_____ If Yes, describe_____

Do you have, or in the past have had, any of the following: Check and Date

No to All (Check this box) ☐	Chemical sensitivities
Cancer and/or tumors (past or present)	Skin infections, lesions, rashes, sores, warts
Blood clots, phlebitis, or inflammation of the blood vessels	Back or spinal problems
	Numbness or tingling
Heart Problems	Asthma (inhaler?)
High blood pressure (taking medication?)	Seizures or convulsions
Low blood pressure	Athletes Foot
Bruises, varicose or spider veins	Hepatitis A, B or C (please circle)
Diabetes or kidney problems	MRSA or Staph Infection
Extreme Fatigue	Cold or Flu
Rapid recent weight loss	Tuberculosis
Allergies, allergy symptoms	HIV/AIDS
Bone or joint problems	Other contagious or chronic infection or disease
Sciatica	(Please List)

— FOR RX MASSAGE ONLY —

INSURANCE CO:_____

Claim/Policy #:_____

Group:_____ Date of Incident:_____

DOCTOR:_____

Phone:_____

ADDRESS: