

Broadleaf Healing Client Intake Form
Confidential Information



Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Occupation: _____

Email Address: _____

How did you hear about Broadleaf Healing? _____

First Myofascial Release Therapy Treatment? Y / N If not, prev. therapist _____

Goal for your therapy: _____

Medication you are currently taking: _____

Past surgeries or traumas: _____

Any emotional history or current conditions your therapist should know? _____

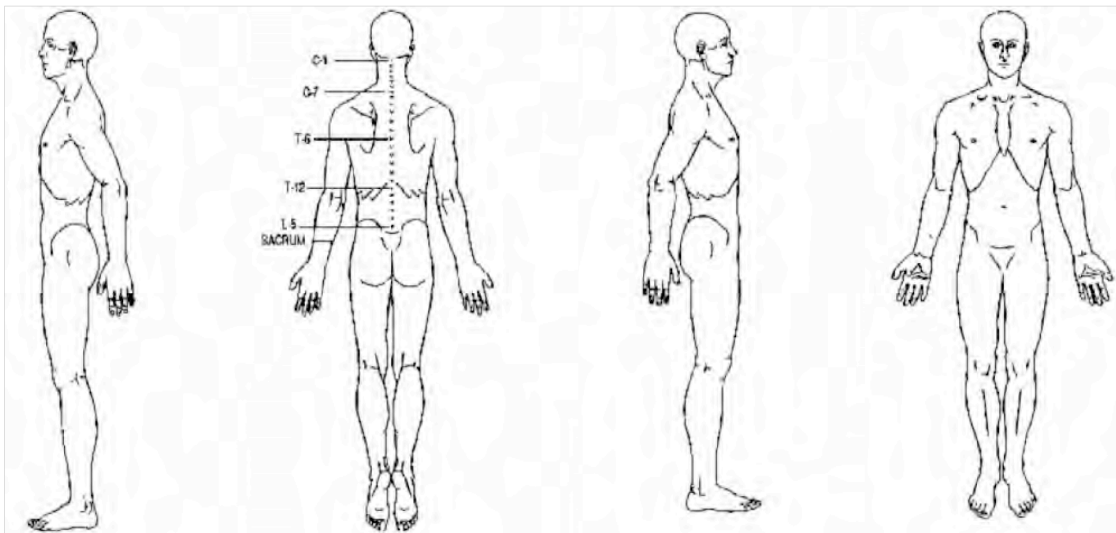
Are you or could you be pregnant? _____

Is there anything else your therapist should know? _____

What are your goals for therapy – short and long term? _____

PLEASE INDICATE AREAS OF PAIN, TENSION AND/OR DYSFUNCTION.

Draw or highlight to show where you feel pain or tension, have limited range of motion, or areas that create dysfunctional symptoms.



Please read the following and sign below:

I understand that massage is not a replacement for medical care and that the therapist will not make a diagnosis. I accept responsibility for seeking medical care through a qualified health care provider. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods can be adjusted to my comfort level. Because message should not be performed under certain circumstances, I agree to keep the massage therapist updated on any changes in my health profile, and I release the massage therapist from any liability if I fail to do so.

Client's signature: _____ Date: _____