



THE BODY IS A SELF HEALING ORGANISM

Name _____ Birthdate/Place/Time _____
Address _____ City _____ State _____ Zip _____
E-Mail _____
Telephone Home _____ Cell _____ Work _____
Occupation _____ Referred by _____

What do you want from this session? _____
Are you here for specific **treatment or stress reduction/relaxation**? _____
Have you experienced bodywork sessions before? _____
Where do you tend to store your tension? _____
When sick, where does it go (ears, lungs, stomach etc)? _____
What do you do to take care of yourself (exercise, hobbies etc)? _____
What sort of support system do you have? _____
What has your energy been like recently? _____
At what times do you feel tired or experience discomfort? _____
If any, what climate conditions effect you most, both positively and negatively? _____

How are your sleeping and eating patterns? _____
Rate on a scale of 1-5 (1 being the least) your consumption of the following:
meat ____ eggs ____ dairy ____ sugar ____ coffee ____ fruit ____ vegetables ____ breads/grains ____

Do you experience any of the following conditions?

Fatigue	PMS	Menstrual Cramping	Joint Pain
High Blood Pressure	Headaches	Constipation/Diarrhea	Kidney stones
Heart Condition	Varicose Veins	Allergies	Other: _____

Have you had any surgeries or accidents, illnesses, traumas, including emotional? _____

Are you currently under the care of a physician or chiropractor - if so, for what condition? _____

Are you pregnant or attempting to become pregnant? _____

Bodyheart Therapy is honored and committed to be a part of your care/maintenance and journey. Our intention for our work with you is partnership. We ask that you keep us informed of any medical changes so that we can continue to serve you through your transformations. Please advise us if you are in need of more information or another type of therapy that we offer or that is available to you somewhere else. We do not diagnose but we will help you to know yourself and increase your body mind awareness.

There may be times when we work in tandem with other health professionals that are consulting with you. Do we have your permission to share our information with other members of your team? Yes No

SIGNATURE _____ DATE _____