THE BODY IS A SELF HEALING ORGANISM

Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Birthdate _____

Telephone Home _____ Cell _____ Work _____

Emergency Contact _____ Referred by _____

Occupation _____

What do you want from this session? _____

Where do you constantly store discomfort in your body? _____

Have you had or do you have:

Hernia	Cancer	Headaches
Pelvic Pain	Head Injuries	Falls to Buttocks
Sexual Abuse	Physical Abuse	Emotional Abuse
Pregnant	Heart Problems	Kidney Stones
Joint Pain	High Blood Pressure	Fatigue
Allergies	Other Traumas	Other

Please explain:

_____

_____

Please advise me of any accident, surgeries or scars from any time in your life: _____

_____

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

_____

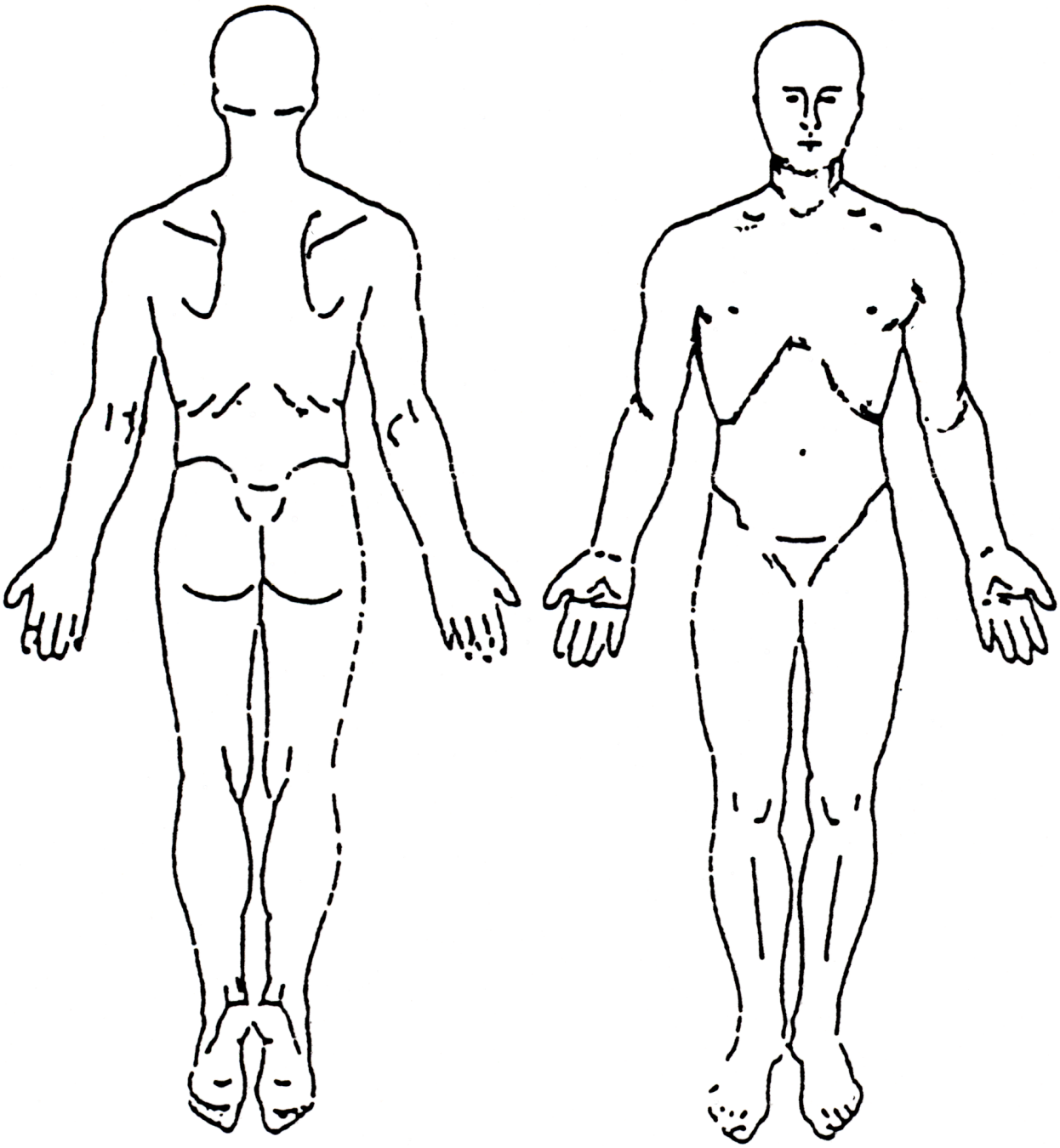
_____

Are you interested in learning some self help techniques? yes / no _____

☐ To avoid being charged in full for your session, if you miss it, 24 hours notice is required.

Bodyheart Therapy is honored and committed to be a part of your care/maintenance and education. I am happy to share with you my awareness and knowledge, however, I do not diagnose.

SIGNATURE _____ DATE _____



Myofascial Release Center of New Jersey

137 Main Street, Chester, NJ 07930 • phone: 908.879.4020

bodyHeart therapy

SALES TAX EXEMPT FORM
WITH DOCTOR'S PRESCRIPTION

Your fees are not subject to sales tax with the following information provided below.

This form must be completely filled out by the referring licensed MD, osteopath, chiropractor, podiatrist, psychologist, or dentist.

Date: _____

Name of Patient: _____

Printed name of referring medical professional:

_____

Signature of referring medical professional:

_____

Purpose of Referral:
MULTIPLE SESSIONS OF MYOFASCIAL RELEASE ON MULTIPLE DAYS

Diagnosis and Description of conditions or needs to be addressed by the massage, bodywork, or somatic therapist:

_____

_____

_____

_____

Thank you,
Sarah Borda, LMT, BCTMB