



Boerne Office - Mon, Tues, Wed, Fri
109 Cibolo Oak Lane Boerne, TX 78006

San Antonio Office - THURSDAY ONLY
(Located in "The Park" Dr. Laura Cioppa)
16607 Blanco Rd, Ste 12105, San Antonio

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"/> Depression/Anxiety | <input type="checkbox"/> Headaches / Sinus | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive-IBS | <input type="checkbox"/> Kidney Conditions | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Neurological-MS | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Endocrine/Thyroid | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Whiplash |

Practitioner notes....

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? _____
- Do you see a Dentist (TMJ) or other Healthcare Professional? 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 _____
- Are you wearing contact lenses? If so, hard or soft? (Circle one)
- Are you wearing Dentures or an appliance? 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 will be draped throughout the session, and the areas that we both agreed upon will be addressed, avoiding personal/private areas. I also understand that the therapist is trained in several soft-tissue modalities and we will decide together which modality is utilized. I understand that the therapist will not engage in breast massage without an additional written statement from me. If I am uncomfortable for any reason, I will inform the therapist to terminate the session.

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

Signed: _____
 Practitioner: _____

Date: _____
 Date: _____