Elizabeth Bosse, Licensed Massage Therapist and Energy Worker
Client Intake Form

Name:_____ Email: _____

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

Phone:(best way to reach you) ( ) C:_____ ( ) H:_____ ( ) W: _____

Occupation:_____

Referred by:_____ Date of Birth:____/____/____

Emergency Contact:_____ Phone:_____

Have you experienced any previous bodywork or energy work? Y or N
If yes, when and what kind?_____

Are you currently under a physician's care for any condition? Y or N
If yes, please explain:_____

Physicians' Name: _____ Phone:_____ Fax:_____

What issues bring you in today? These symptoms can be physical, mental, emotional, or spiritual.

_____

_____

How long have you been experiencing this? _____

Have you been given a medical diagnosis? Y or N? Please Explain:_____

Are there behaviors or thoughts that aggravate the situation? _____

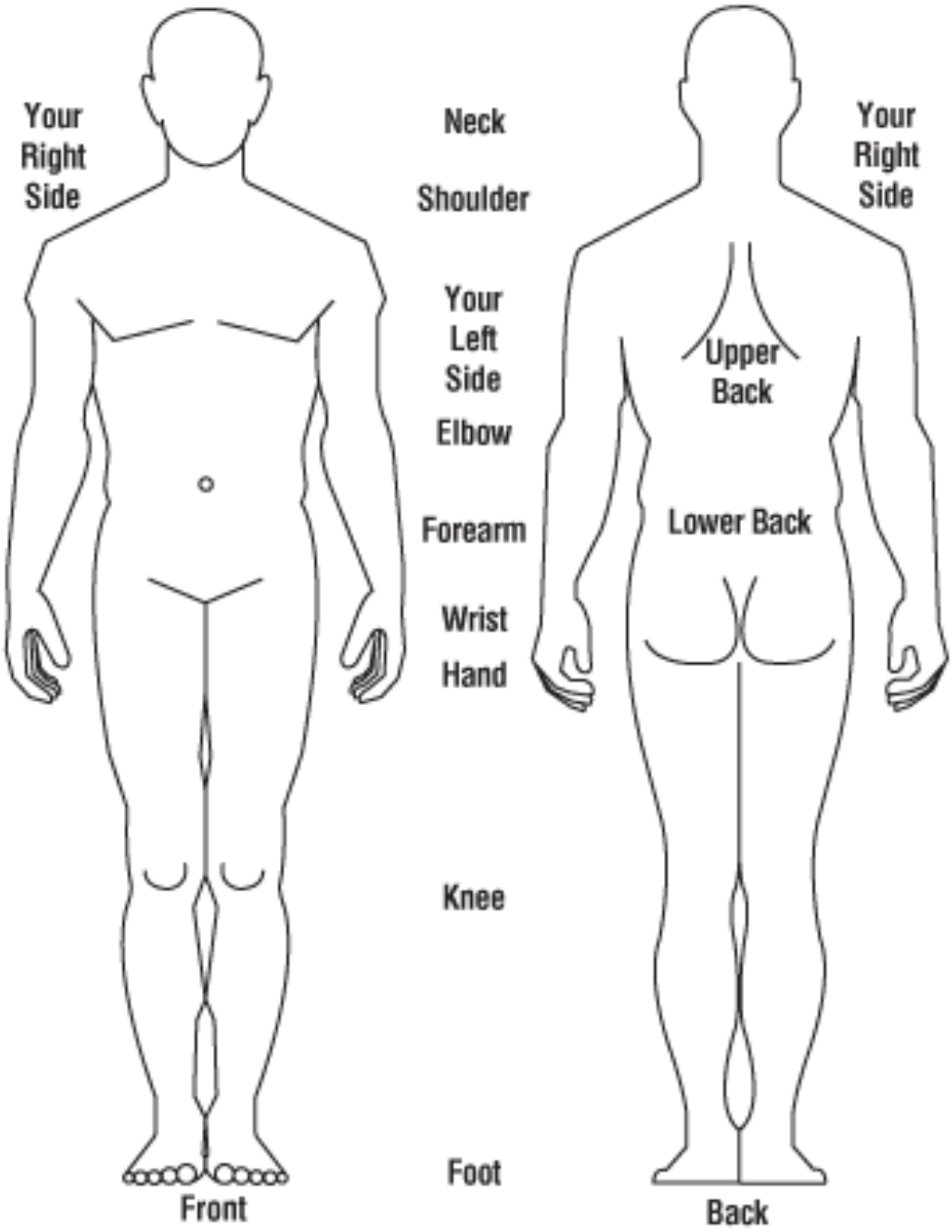
_____

Please answer the following questions:

Y or N Do you wear contact lenses?
Y or N Do you wear dentures?
Y or N Have you had extensive dental work (braces, crowns, etc.) _____
_____
Y or N Do you have any allergies? If yes, please list them._____
_____
Y or N Do you have arthritis? What type and where? _____
_____
Y or N Do you have any heart problems? _____
_____
Y or N Do you have any circulatory problems? Any tingling or numbness? _____
_____
Y or N Do you have any spinal problems? _____
_____
Y or N Do you have bone or joint problems? Bone loss? Pain or limited movement in joints? TMJ? _____
_____
Y or N Do you have any respiratory problems? _____
_____
Y or N Do you have any digestion or elimination problems? _____
_____
Y or N Do you have any trouble sleeping or feelings of tiredness? _____
_____
Y or N Do you have any hearing problems? Ringing in the ears? _____
_____
Y or N Are you presently pregnant? How far along? Any complications? _____
_____
Y or N Have you had any surgery? How recently? Complications? _____
_____
Y or N Do you have varicose veins or blood clots? Please indicate where. _____
_____
Y or N Do you have any skin problems, diseases, or open sores? Where: _____
_____
Y or N Do you take any prescribed medications? Please list name and purpose: _____
_____
Y or N Do you take any supplements or herbs? Please list name and purpose: _____
_____

Y or N Do you exercise or play sports on a regular basis? Please describe: _____
_____
Y or N Are you receiving any other complementary care currently (chiropractor, naturopathic, acupuncture, etc.) If so, please describe. _____
_____
Y or N Do you have any other physical or mental condition of which I should be aware before starting this Session? _____

Please use one of the drawings on the following pages to indicate areas of discomfort or unusual sensations that you experience. Show the size and the location of the sensations. Add any comments, as you feel called. *Remember, your right side appears on the left side of the page when facing the picture*.



Please read and initial:

_____ I understand the massage, craniosacral therapy, lymph drainage, or Reiki is for the purpose of stress reduction, emotional healing, relaxation of muscles, better circulation of lymph, cranio fluid, and energy throughout the body.

_____ I understand that massage, craniosacral therapy, lymph drainage, or Reiki does not diagnose illness, disease, or any other physical or mental disorders. In addition, the massage therapist does not prescribe medical treatments or pharmaceuticals.

_____It is understood that any illicit or sexually suggestive remarks or advances on the client's part will result in immediate termination of the massage session, and the client will be liable for payment of the full scheduled appointment.

_____I understand that massage, craniosacral therapy, lymph drainage, or Reiki is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

_____Because the therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting form disclosed and undisclosed conditions.

Client Signature:_____Date:_____

Practitioner Signature:_____Date:_____

Consent to Treat a Minor

By my signature below, I hereby authorize Elizabeth Bosse, LMT to administer massage or craniosacral therapy to my child or dependent as they deem necessary. I understand that I, as the parent or guardian, must be in the room during the session.

Signature of Parent or Guardian: _____Date:_____