Season Day Spa

Client Intake Form – Bodywork

Personal Information:

Name _____ Primary Phone _____

Address _____

City/State/Zip_____

Email_____ Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

The following information will be used to help plan safe and effective Bodywork sessions. Please answer questions to the best of your knowledge.

1. How would you rate the current state of your health: Excellent Good Fair Poor

2. Are you currently under a doctor's care? If so, explain: _____
_____

3. For women, are you pregnant? Yes/No If yes, how far along? _____

4. List other therapies besides conventional medicine or chiropractics in which you are currently participating:_____

5. Are you taking any medication? If so, what? _____
_____

6. List previous major illnesses, accidents, surgeries or broken bones: _____
_____
_____

7. Are you experiencing any problems with your feet? If so, explain: _____
_____

8. Where is tension most evident in your body? _____

9. Have you experienced Bodywork before? If so, when? _____

10. Do you have any specific goals for our session? _____
_____

To the Clients of Bodywork

You need to know that:

1. I am not a doctor.
2. I do not practice medicine.
3. I do not diagnose or treat for a specific illness.
4. I do not prescribe or adjust medication.
5. Bodywork is not a substitute for medical treatment, but is a complement to most types of therapy.

By signing this form, I give my consent to a Bodywork session. I understand that I may discontinue a session or sessions at any time. If I have been diagnosed by a licensed health professional as having any disease, injury or other physical or mental condition, I understand that I should inform the person who made the diagnosis, about the session I will be receiving, and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy, I assume responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

Signature _____ Date_____

Print Name _____

25 Brook Rd Needham MA 02494