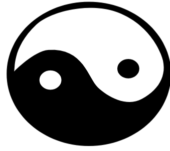

Intueri Bodywork Studio

healing begins within

160 East Main Street, Suite 1E
Westborough, MA 01581
(508) 259-8972
chertwolf65@gmail.com

Confidential Client Information & Health History

Name: ______________________ Today's Date: ____________
Address: ______________________
City, State & Zip: ______________________
Home # ____________ Work # ____________ Cell: ____________
Email: ______________________ DOB: ____________
Partner's Name: ______________________

Occupation: ______________________

List the types of bodywork have you experienced (if any): ______________________

What kind of exercise (if any) do you do? (please include frequency): ______________________

List your areas of discomfort or pain (if any): ______________________

List any traumas or significant life events that you are comfortable sharing: ______________________

Are you on a special diet or do you have any food allergies? ______________________

Do you drink alcohol? If so, how much per week? ______________________
List any other addiction issues: ______________________

List medications (including pain relievers and supplements) you currently take: ______________________

List past surgeries, broken bones, injuries or spinal issues: ______________________

Please mark "C" for chronic issues and "A" for acute, recent issues

E

________	painful joints/arthritis	______	ear problems
________	thyroid imbalance	______	nervousness
________	burnout	______	grief (old or new)
________	need for space	______	communication issues
________	irritability	______	insomnia
________	self-pity	______	sinus issues
________	fatigue	______	no free time

A

________	asthma	______	cigarette addiction
________	heart issues	______	fears/paranoia
________	memory loss	______	headaches
________	epilepsy/seizures	______	shortness of breath
________	sleeping difficulties	______	loss of smell
________	shoulder issues	______	pneumonia
________	allergies	______	fainting

F

________	cold hands/feet	______	high blood pressure
________	liver issues	______	anger issues
________	gallbladder issues	______	lack of energy
________	stomach issues	______	eye issues
________	indigestion	______	diabetes
________	ulcers	______	lack of concentration

W

________	psoriasis	______	depression
________	low blood pressure	______	reproductive disorders
________	loss of taste	______	bags under eyes
________	menstrual issues	______	trouble going with the flow
________	over emotional	______	bladder/kidney issues
________	urination/prostate issues	______	anemia
________	swollen ankles	______	burning/pain during sex

E

________	overweight	______	holding on to things (including emotions)
________	neck issues	______	constipation/diarrhea
________	lack of balance	______	stubborn
________	lethargic	______	not feeling grounded
________	colon issues	______	lack of enthusiasm
________	feeling resentful	______	gas

Other notable issues: ____

I understand that any session with the therapist should not be construed as a substitute for medical examination, diagnosis or treatment. I will see a physician, chiropractor, psychotherapist or other qualified medical specialist for any physical, emotional or mental ailment. If I experience any pain or discomfort during the session, I will immediately notify the therapist. I have reported all known health conditions and will inform the therapist of any changes in my health status.

Signature: ______________________________ Date: ______________

Cancellation policy: Please give at least 24 hours notice prior to your appointment. Without notice, you will be responsible for 50% of the session's cost. Please call or email with any questions. Thank you.