BRENNAN INSTITUTE FOR MIND-BODY HEALING

Wellness New Client Intake Form

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Welcome to Brennan Institute for Mind-Body Healing! Here follows some essential information about our practice. Please read and sign at the bottom to indicate that you have reviewed and agree with this information.

Length and frequency of treatment: Duration and frequency vary depending on the nature of your problem and your individual needs.

Fee and Cancellation Policies: Fees are collected at the time of service unless alternate arrangements are made in advance. No refunds are available for services/packages. If you need to cancel an appointment, please provide at least 24 business hours advance notice; otherwise, you will be charged for the session. Emergency medical or family situations are the only exceptions. In signing this services contract, you agree to have fees for late cancellation or no-shows, and any unpaid balances charged to a credit card on file. Please provide relevant credit card information below. Your credit card account information will be kept secure and confidential.

Name of Cardholder (as appears on card):_____ Card #:_____
CVV# (security code): _____ Exp. Date (month/year): _____ Billing Zip Code: _____

Client Signature_____ Date_____

Client Name_____ **Birth date:_____**

Address:_____

Home phone:_____ **Cell phone**:_____

Email:_____ **Occupation**:_____

What is your preferred method of contact (phone or email)? _____

Can we send you information/updates at this email? _____

Referred by:_____

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What brings you in today? What is your goal for this session? _____

Have you had a professional massage/bodywork before?_____ **If yes, what kinds?**_____

_____

What areas would you like me to work on today? Are there any areas you would like me to avoid?

_____

Are you presently under a physician's/therapist's care? ____ **If yes, please provide some details.**__

_____

Please list any health challenges you are facing as well as any major illnesses you suffered in the past. Please include surgeries and injuries/traumas. *(Injuries/traumas can be of a physical, mental, or emotional nature.)* _____

_____

Do you experience any pain or sites of tenderness/stiffness? _____ **If yes, what is the quality** *(i.e. radiating, shooting, aching, numbness, swelling)* **and duration of the pain/sensation?** _____

_____

How do you typically manage pain? What aggravates or relieves it? _____

Please list any medications you are currently taking, their purpose and any side effects *(please include over the counter medications*). _____

_____

Do you smoke?_____ **Do you wear contact lenses?** _____ **Is fragrance ok?** _____

Do you have any allergies? _____ **If yes, please list them**_____

Is it possible you are pregnant?_____ **If pregnant, list your due date.**_____

What exercise/fitness/physical activity(ies) do you do? How often? How do you spend your free time?

_____