BODY-OLOGY
Healing body, mind & spirit

Please indicate the symptoms from which you are seeking healing and relief. Place a check in front of each item that you experience at least monthly:

☐ Headache
☐ Heard pounding/racing
☐ Irregular heartbeat
☐ Chest pain/tightness
☐ Numbness/tingling in arms or legs
☐ Can't keep warm enough
☐ Sweaty Palms.
☐ Blushing/flushed face
☐ Coughing
☐ Stuffy Nose/Congestion
☐ Ear ache or ringing noise in ears
☐ Common cold
☐ Sore throat
☐ Asthma or shortness of breath
☐ hay fever or allergies
☐ Sore, aching muscles
☐ Stiff or tender joints
☐ Back problems
☐ Trembling or twitching muscles
☐ Skin rashes, eruptions
☐ Grinding of teeth or TMJ
☐ Dry mouth
☐ Mouth Sores
☐ Excessive Perspiration
☐ Difficulty sleeping through the night
☐ Excessive drowsiness during the day
☐ Periods of extreme fatigue
☐ Feeling faint or dizzy
☐ Feeling tense or nervous
☐ Recurring bad thoughts
☐ Difficulties with family or friends
☐ Worrisome thoughts
☐ Thoughts of suicide
☐ Fearful of persons or places

☐ Feeling inadequate/unable to cope
☐ Feeling guilty or failure
☐ Uncontrolled crying or sadness
☐ Easily annoyed or irritated
☐ Free-floating anxiety about life
☐ Voice quivering or shaking
☐ Eyes irritated or inflamed
☐ Vision Blurred
☐ Eyestrain or discomfort
☐ Nosebleeds
☐ Stomach cramps
☐ Heartburn or indigestion
☐ Nausea or vomiting
☐ Frequent urination
☐ Incomplete urination
☐ Painful urination/urgency
☐ Incontinence
☐ Bowel leakage
☐ Gas in lower bowel
☐ Diarrhea
☐ Constipation
☐ Bowel irregularity
☐ Disinterest in sexual relations
☐ Unable to participate in sex
☐ Menstrual difficulties
☐ Breast tenderness
☐ Hot flashes
☐ Water retention
☐ Over-eating/bingeing
☐ Lack of appetite
☐ Excessive alcohol consumption
☐ Other substance abuse
☐ Frequent Laxative use

Past Medical History: Please list any surgeries, traumas, accidents or other conditions, the approximate dates on which they occurred, as well as any other symptoms or concerns:

Ilena Benjamin, MA, LMT
Ilena@Body-ology.com | ***941-238-8264***
FL Cert #68015 National Cert #613737-12

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INTAKE FORM

Name: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____

Age: _____ Date of Birth: _____ Marital Status: S M D W

No. & Age of Children: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Employer: _____ Occupation: _____

Referred by: _____

Please initial each item below and sign at bottom.

_____ I understand that I am responsible for payment in full at the end of each session, and that a receipt will be made available upon request if I wish to file a claim with my private insurance.

_____ I have been advised of the potential risks and side effects of myofascial release and massage therapy in general and I freely and voluntarily consent to treatment.

_____ I hereby agree to hold Ilena Benjamin, MA, LMT harmless for any and all claims and liabilities associated with or proceeding from treatment.

Signature: _____ Date: _____

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Ilena Benjamin, MA, LMT
Licensed Massage Therapist

Informed Consent to Massage Therapy Treatment

I hereby consent to examination by my Massage Therapist, which may involve removal of some clothing articles, palpation (manual examination) of body part(s) and close examination of body part(s).

I hereby consent to treatment by my Massage Therapist, within her scope of practice. I understand that the treatment will be discussed with me prior to its application and that at any time, I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks, and the potential risks associated with massage therapy have been explained to me. I understand and assume these risks.

I acknowledge that my massage therapist must be fully aware of all my existing medical conditions in order to safely administer therapy. I have completed a medical history form and have disclosed to my Massage Therapist all of the medical conditions affecting me. It is my responsibility to update my therapist on any injuries or changes in my health or medical history.

I have read the above noted consent. By signing this form, I consent to evaluation and treatment by my Massage Therapist. I understand that at any time, I may withdraw my consent and treatment will be stopped, and that my consent will continue until such time as I withdraw it.

_____	_____
Print Name	Signature/Date
_____	_____
Witness	Signature/Date

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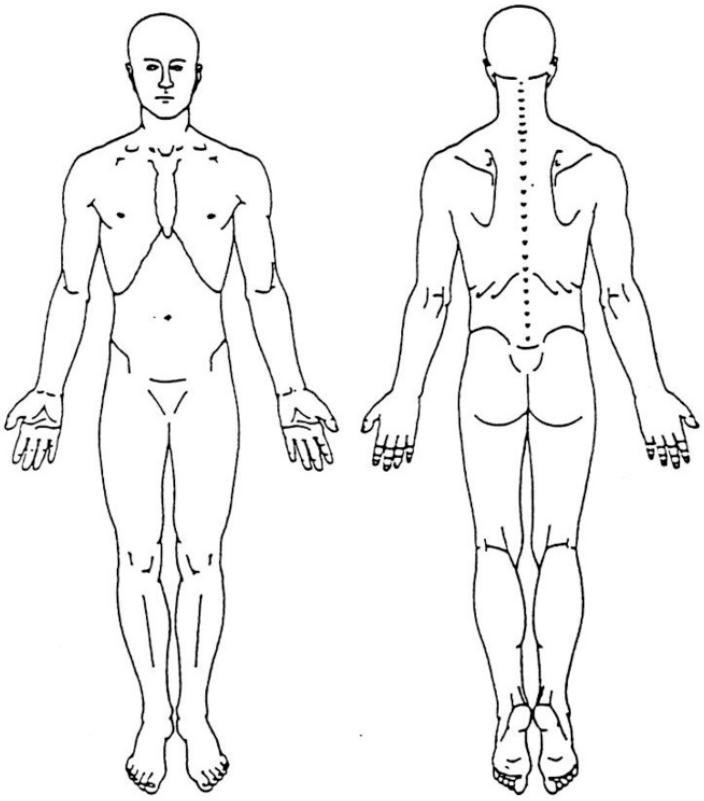
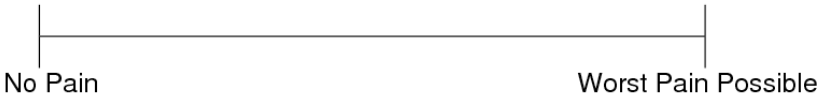
Body Diagram

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



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