poolesville healing arts

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Client Information

Date of Initial Visit _____

Name _____ Age/DOB _____
Address _____
_____
Telephone (H) _____ (W) _____
(C) _____ Email_____
Occupation _____ Referred by _____
Sports/Hobbies _____

Previous Bodywork Experience _____

Goals for Today's Session_____
_____

Are you presently under the care of a physician? _____ If yes, may I contact him/her?
Name and # of Dr. _____
_____

Please fully explain all physical, mental and/or emotional issues that may affect the session: _____
_____
_____

Our sessions are completely confidential; I will not share your personal information with anyone, professional or otherwise, without your specific permission. Also, all session are non-sexual. Any attempt to sexualize our relationship will result in immediate termination of the session and you will be responsible for full payment.

Signature _____