Boulder Body Balance Acupuncture Clinic LLC
2515 Broadway St, Boulder, CO 80304
(720) 509-9588
http://boulderbbacupuncture.com/

New Patient Massage Intake Form

Name		Date	
Street Address		Sex	
City State Zip		Date of Birth	
Mobile Phone	Marital Status	Height	Weight
Work Phone	Home Phone		
Maiden/ Former Name	Email		
Primary Physician	Emergency Contact		
Relationship	Phone number		
Occupation	Referred by		

Medical History

What is your primary health complaint/ concern?

_____

_____

Have you seen a MD for this complaint/ concern? Was there a diagnosis?

_____

_____

Please list all surgeries and hospital stays; please include the date and procedure:

_____

_____

Please list all significant traumas (auto accidents, falls, broken bones) and dates:

_____

_____

Please list ALL allergies, include food sensitivities:

_____

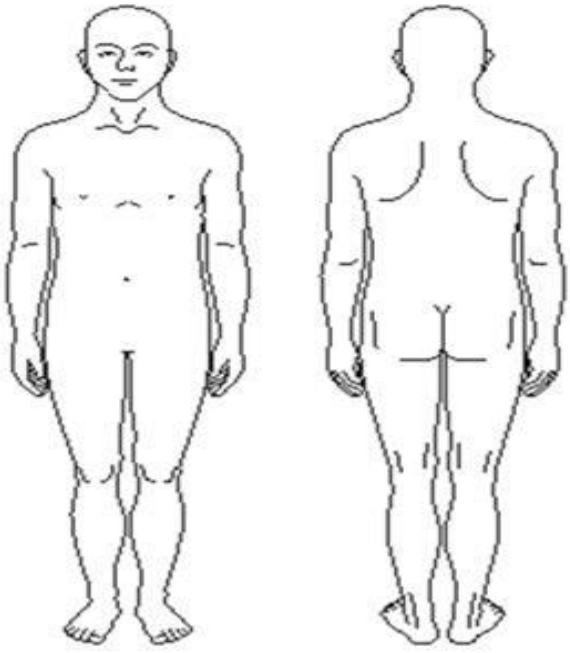
_____

If you have been diagnosed with a psychological/ emotional problem, please explain:

_____

_____

_____



Please place an X on your problematic areas.

Informed Consent

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment at time service is rendered. I authorize Boulder Body Balance Acupuncture Clinic LLC to contact me at the above contact information. I understand that I am responsible for all returned checks and must pay the price on the check plus a $30 bounced check fee. I understand that my personal information is private and will not be shared with anyone unless a written request is made to Boulder Body Balance Acupuncture Clinic LLC written and signed by me.

Massage Therapy is considered safe, and it is my responsibility to inform Boulder Body Balance Acupuncture Clinic LLC if any changes in my health occur. I am responsible for informing Boulder Body Balance Acupuncture Clinic LLC of any and all health conditions, diseases or disorders from which I suffer. Serious health conditions or injuries will be referred to the appropriate physician, clinic or hospital.

I understand that I still need to continue any medical treatment that I am receiving through my physician. I understand that I have the right to refuse treatment at any time, and I have the right to end my treatments at any time. I also understand that I have a right to ask whatever questions I have before, during, or after my treatments. I understand that Boulder Body Balance Acupuncture Clinic LLC is not to be held responsible for any unexpected complications that may occur.

I voluntarily consent to being treated by Boulder Body Balance Acupuncture Clinic LLC in any of the following ways:

I understand the treatment or treatments that I am about to receive. I have read this consent form, and I completely understand what I am signing. I consent to be treated at Boulder Body Balance Acupuncture Clinic LLC, and I agree to abide by all terms and conditions before mentioned.

_____

Patient's or Guardian's Name Printed **Date**

_____

Patient's or Guardian's Signature **Date**