

# Client Intake Form

Victoria Soo dba Bodywork by Victoria

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## Personal Information

- Full Name: \_\_\_\_\_
- Date of Birth (MM/DD/YYYY): \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Address: \_\_\_\_\_
- Emergency Contact Name: \_\_\_\_\_
- Emergency Contact Phone Number: \_\_\_\_\_

*Privacy Notice:* Your email will only be used for appointment communication and follow-up. It will never be sold or used for marketing.

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## Health History

1. Please check any current or past medical conditions:  
[ ] Heart Disease [ ] High Blood Pressure [ ] Diabetes [ ] Seizures [ ] Cancer [ ] Blood Clots  
[ ] Pacemaker or implanted device [ ] Metal Implants [ ] Skin Conditions [ ] Pregnancy [ ] Recent Surgery [ ] Other: \_\_\_\_\_
2. Current medications and supplements: \_\_\_\_\_
3. Allergies (including adhesives, latex, medications): \_\_\_\_\_
4. Are you currently under the care of a physician?  
[ ] Yes [ ] No If yes, please specify condition: \_\_\_\_\_
5. Primary reason for seeking treatment today: \_\_\_\_\_
6. Surgical history (if any): \_\_\_\_\_

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## Current Symptoms

- Location of pain/discomfort: \_\_\_\_\_
- Duration of symptoms: \_\_\_\_\_
- What makes symptoms better or worse? \_\_\_\_\_

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## Goals & Preferences

- What are your goals for treatment? \_\_\_\_\_
- Areas you do NOT want treated: \_\_\_\_\_
- Preferred pressure for massage (if applicable): [ ] Light [ ] Medium [ ] Deep

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## Therapy Interest & Consent

Please check all therapies that interest you or you have questions about:

Massage Therapy  Lifestream Generator  Frequency Specific Microcurrent (FSM)  Cupping Therapy  
 IASTM  Massage Therapy

I understand that my provider may use one or more of these therapies during my treatment as appropriate. I consent to receive any recommended therapies, even if I have not checked them above.

Initials: \_\_\_\_\_

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## Previous Experience

- Have you received any of these therapies before?

Yes  No If yes, please list: \_\_\_\_\_

- Any adverse reactions or concerns? \_\_\_\_\_

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## Acknowledgement, Consent & Release

By signing below, I acknowledge that:

- I have provided accurate and complete health information.
- I understand the nature, purpose, risks, and benefits of the therapies offered.
- I understand and accept that no specific results or cures are promised or guaranteed.
- I may refuse or discontinue any therapy at any time.
- I have received and agree to abide by the practice policies including cancellation, refund, and payment terms.
- I voluntarily consent to receive care and release Victoria Soo dba Bodywork by Victoria and staff from liability as described in the full consent and release documents.

Patient Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please discuss any questions or concerns with your provider before signing.*

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How did you hear about Bodywork by Victoria?  Google  Yelp

Referral from friend/family (please specify): \_\_\_\_\_

Other: \_\_\_\_\_