



BELLA VIA
Skin and Body Therapies

BODY THERAPIES FORM

Name: _____ DOB: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____ Occupation: _____

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)

Dr. Colville Dr. Zavell Website Friend: _____

Other: _____

MEDICAL HISTORY

Please check any of the following conditions that apply to you:

- | | | |
|---------------------------------|-------------------------------|------------------------------|
| _____ Arthritis/Rheumatism | _____ Asthma | _____ Back Pain |
| _____ Blood Clots | _____ Bursitis | _____ Cancer: type _____ |
| _____ Carpal Tunnel Syndrome | _____ Diabetes | _____ Eczema/Psoriasis |
| _____ Fibromyalgia | _____ Frequent Headaches | _____ Heart Problems |
| _____ Hepatitis | _____ High/Low Blood Pressure | _____ Infectious Disease |
| _____ Immune Deficiency Disease | _____ Joint Problems | _____ Lymph Node Removal |
| _____ Migraine Headaches | _____ Nail/Foot Fungus | _____ Open Wounds/Infections |
| _____ Sciatica | _____ Seasonal Allergies | _____ Thyroid Condition |
| _____ TMJ | _____ Torn Rotator Cuff | _____ Varicose Veins |

Do you suffer from excessive stress or depression? If yes, please explain: _____

Do you have circulation problems or do you bruise easily? _____

Do you have any allergies to lotions/oils, seaweed/iodine, or medications? _____

Have you ever had a stroke or any other major injury? If yes, please explain: _____

Do you wear contact lenses? _____

Are you pregnant? If yes, when is your expected due date? _____

Are you breast-feeding? _____

Do you participate in physical/sports activities? If yes, which types and how often? _____

List all surgeries you have had within the last five years: _____

List any medications, herbals, and vitamins that you are currently taking: _____

Do you have any other medical condition(s) that your technician/therapist should know about? If yes, please explain: _____

OCCUPATIONAL CONCERNS

Please check any of the following conditions that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heavy lifting | <input type="checkbox"/> Hazardous substances | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Repetitive functions | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Prolonged standing |

BODY SPECIFICS

What are your expectations of the body treatment you will receive today? _____

Do you prefer a light or firm touch with your massage? _____

Are you interested in aromatherapy incorporated into your treatment today? _____

Do you prefer a full-body massage, or do you have specific muscle groups that you would like your therapist to focus on during your massage? _____

Where are your specific areas of complaint, pain or tension? _____

Have you had a professional massage before? _____

 If yes, when? _____

 If yes, do you receive massages on a regular basis? _____

Do you have any spinal problems? _____

Are you especially sensitive to touch/pressure in any specific areas? _____

Do you have difficulty falling asleep at night? _____

Do you get muscle cramps? If yes, where? _____

By signing below, I agree to the following statement:

I understand that my body therapy session is provided for the basic purpose of stress reduction, relief from muscular discomfort, and for help in increasing blood, lymph, and energy circulation. I have stated all known medical conditions and I will keep the massage therapist updated on any changes regarding my health. I claim full responsibility for services rendered.

Signature: _____

Date: _____

Thank you for visiting Bella Via!



Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

Craig W. Colville, M.D., F.A.C.S.
John F. Zavell, M.D., F.A.C.S.