



BREATH OF LIFE INTAKE FORM

First Name _____

Last Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email address _____

Consent of Professional Services

I hereby authorize Marya Gendron, LMT, to administer any services that she deems necessary in my case.

Patient/ Responsible Party signature _____ Date _____

Cancellation Policy: Please give 24 hours notice if you cannot make your scheduled appointment. Cancellations without notification will be charged in full.

Health Goals: What are your most important health goals? Please list in order of importance to you:

1. _____

2. _____

3. _____

Chief Concern - Explain the main reason you are seeking care:

Duration of Present Condition: _____

On a scale from 0 (no pain) to 10 (most intense pain imaginable) please rate your pain today: _____

Rate your pain when it first began: _____

Rate your pain at its worst: _____

What do you believe caused this condition?

What makes it better?

What makes it worse?

When and how did it begin?

Goals: What are your goals/expectations for this session?

Medication you are presently taking:

Self-care: please describe any physical, spiritual, or creative practices that give your life balance)

History of Trauma/Injury

Please describe any significant accidents, injuries, trauma, or illnesses in the past _____

List any other hospitalizations or surgeries you have had. Include age, time and any problems since:

Stress/Management

What do you do to relax? _____

