



**Jessica Ippoliti, LMT**  
**415-847-9584**

**Confidential Client Intake Form**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Referred by: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Current Problem Area: \_\_\_\_\_

Are you currently seeking other treatment (i.e. phys. therapy, chiro)? Yes \_\_\_\_ No \_\_\_\_

Main Activity: \_\_\_\_\_

What movements are limited? \_\_\_\_\_

List all past injuries and surgeries you've had: \_\_\_\_\_

\_\_\_\_\_

List all prescriptions, drugs, herbs, and/or vitamins you're discs: \_\_\_\_\_

\_\_\_\_\_

List all medical conditions (from contacts to diabetes to bulging discs): \_\_\_\_\_

\_\_\_\_\_

I am responsible for the charges of all services provided at the time they are provided. I understand the benefits and risks involved and give my consent for bodywork to my therapist. I will consult my therapist with any questions or concerns that I have. I have stated all medical conditions and will keep my therapist informed of any changes.

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

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