Freedom from Body Memory

Awaken the Courage to Let Go of the Past

BMR Intake Form

Name: ____ Date: _________________________

Address: ____ Phone: ___________________________

City, State, Zip: ____ Date of Birth: ____________________

Email: ____ Occupation: _____________________

I am informed about the Body Memory Recall approach (circle) Yes/ No
If yes, from what sources have you been informed? _ BMR Treatment Brochure, _ By a therapist/healthcare practitioner, _ Freedom From Body Memory- the book, _ BMR website. If other, explain:

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Reason for today's visit: _decrease pain, _ release stress, _ release suppressed emotion, _ release trauma, _ increase energy, _ increase range of motion. Please share specific reason you are seeking BMR treatment:

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Mark "*X* " for previous conditions. Mark " ✓" for current conditions.

_ muscle/bone injuries _ sprain/strain _arthritis/tendonitis _ abdominal/digestive problems
_ numbness/tingling _ sinus congestion _ pregnancy _ varicose veins _ heart/circulatory problems
_ high/low blood pressure _ allergies _ blood clots _ infectious disease _ cancer/tumors _ dental problems
_ surgeries _ asthma/lung conditions _ accidents _ other medical conditions _ scar tissue

Please explain____

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Current medications, including aspirin, Ibuprofen, vitamins, etc.: ______________________________________

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By signing below, I indicate that I understand that BMR is not a massage, massage therapy or any other form of medical treatment, but rather it is a spiritual, hands on healing approach in which I request and consent to receive from Colleen Brown, a BMR practitioner and Licensed Massage Therapist.

Signature: ____ Date: ___________________