



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:

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:

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 _____

Current medications, including aspirin, ibuprofen, vitamins, etc.: _____

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 Jonathan Tripodi, a BMR practitioner and ordained minister of the Universal Life Church Monastery.

Signature: _____ Date: _____