



# 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: \_\_\_\_\_