7862 N. Academy Blvd.
Colorado Springs, CO 80920
Phone 719-424-7565
Fax 719-559-1710

Client Intake

Date: _________________

Name: ______________________________ Date of birth: _____________ Height: _________ Weight: ______

Emergency Contact: __________________________ Phone: ________________ Relationship: _____________

Have you received prosthetics and/or bras within the last two years? ___ Y ___ N

If yes, what facility & when? ____

Breast Surgical History (include date and whether left, right, or bilateral)

1) ____
2) ____
3) ____

Do you have any of the following (if yes, please explain):

- Drains ___ Y ___ N ____
- Sensitivity ___ Y ___ N ____
- Skin Allergies ___ Y ___ N ____
- Keloid Scars ___ Y ___ N ____
- Lymph Node Removal ___ Y ___ N Biopsy Results ____
- Chemotherapy ___ Y ___ N ____
- Radiation ___ Y ___ N ____
- Lymphedema ___Y ___ N ____
- Range/Motion Issues ___ Y ___ N ____
- Arthritis ___ Y ___ N ____
- Other Cancer ___ Y ___ N ____

Activity Level:

- Significant weight change in the last year ___ Y ___ N _______________________________________
- Actively dieting at this time ___ Y ___ N ____
- Planning to diet in near future ___ Y ___ N ____
- Do you exercise ___ Y ___ N ____

Did you bring someone with you today? ___Y ___ N If yes, name? ____________________________________

We welcome your friends or family to all visits. Please be aware that your medical information may be disclosed to your guest. By allowing your guest into the treatment room with you, you are granting disclosure to such individual. Thank you for your understanding. – *Tracey's Boutique*

I hereby declare that I have answered the above questions truthfully and to the best of my knowledge.

Signature: ____ Date: ____________________