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BODYWORK INTAKE FORM PERSONAL HEALTH INFORMATION

PERSONAL DATA

Date _____ Referred by _____

Name _____

Address (city-state-zip) _____

Phone (cell-home-work) _____

Email _____

Employer/Occupation _____

Birthdate _____

Emergency Contact/Phone number _____

INSURANCE INFORMATION

Insurance Carrier _____

Name of insured _____

ID# _____

Group# _____

Copay Amount _____

Referring Provider/Phone number _____

Permission to consult with them? (Y/N) _____

BODYWORK HISTORY/TREATMENT

Have you ever received professional massage or structural bodywork? (Y/N)

If yes, frequency, date of last treatment: _____

What results do you want from your session? _____

Prioritize the areas of your body where you need the most attention: _____

Are there any areas of the body you would prefer not be touched? _____

Are you currently seeing a medical practitioner? (Y/N)

Please explain if yes: _____

List stress reduction and exercise activities, including frequency: _____

List current medications and purpose: _____

PREVIOUS HISTORY

This information helps me to understand your body's compensation patterns.

Please include year and treatment received.

Surgeries/hospitalizations:

Accidents:

HEALTH HISTORY

I am interested in what is currently happening with your body, and in all historical issues that significantly influence your current relationship with your body. Please mark any of the following with a short explanation (if needed).

MUSCULO-SKELETAL

- Bone or joint disease
- Tendonitis
- Bursitis
- Broken/fractured bones
- Arthritis
- Sprains/strains
- Low back/hip/leg pain
- Neck/shoulder/arm pain
- Headaches/head injuries
- Spasms/cramps
- Jaw pain/TMJ
- Lupus
- Spinal problems
- Other/explain _____

CIRCULATORY

- Heart condition
- Phlebitis/Varicose veins
- Blood clots
- Thrombosis/Embolism
- High/Low blood pressure
- Lymphedema
- Sinus problems/Allergies
- Other/explain _____

INFECTIOUS DISEASE

- Disease name(s) _____
- _____
- _____

SKIN

- Allergies
- Rashes
- Athletes Foot
- Warts
- Other/explain _____

DIGESTIVE

- Constipation
- Diverticulitis
- Ulcers
- Irritable Bowel Syndrome
- Other/explain _____

NERVOUS SYSTEM

- Herpes/Shingles
- Numbness/tingling
- Chronic pain
- Chronic Fatigue
- Sleep Disorders
- Other/explain _____

REPRODUCTIVE

- Pregnant? Week: _____
- PMS
- Ovarian/Menstrual Problems
- Other/explain _____

OTHER

- Cancer/Tumors
- Diabetes
- Eating Disorders
- Depression
- Anxiety
- Addictions
- Contact Lenses (hard or soft)

ADDITIONAL REMARKS:

I have completed this form to the best of my knowledge and will inform the practitioner of any change in my health status. I understand that the practitioner cannot diagnose illness, disease, or any other medical, physical, mental or emotional disorder, nor perform spinal thrust manipulations. I am responsible for consulting a qualified physician for those services. I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed _____

Date _____