Bodyworks
THERAPY

NEW CLIENT FORM

Name _____ D/O/B _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____

Email _____ Occupation _____ Employer _____ Referred by _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Insurance Information

Primary

Full name_____ D/O/B _____

Insurance Provider _____ Insurance group #_____

Billing address_____

city_____ state _____ zip_____ Phone_____

Secondary

Full name_____ D/O/B _____

Insurance Provider _____ Insurance group #_____

Billing address_____

city_____ state _____ zip_____ Phone_____

(circle all that apply)

Are you seeking treatment from an auto accident/A work injury/A health condition?

Client's relation to insured? Self/ Spouse/ Partner/ Child

Date of Injury (If applicable) _____

Current Health

Reason for initial visit _____

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PH:907.344.0376 FAX: 907.344.0708

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List surgeries and year _____
_____

Do you have sensitive skin? _____ Do you have any allergies to oils, lotions or ointments? _____

List any known allergies _____

Current medications _____
_____

Circle Any Conditions that Apply

Musculoskeletal

Bone or Joint Disease/ Tendonitis /Bursitis /Arthritis /Gout/ Jaw Pain (TMJ)/ Lupus

Spinal Problems/ Migraines/ Headaches/ Osteoporosis

Circulatory

Heart Condition/ Phlebitis /Varicose Veins/ Blood Clots/ High Blood Pressure

Low Blood Pressure/ Lymphedema/ Thrombosis/ Embolism

Respiratory:

Breathing Difficulty/ Asthma/ Emphysema/ Sinus Problems

Nervous System:

Shingles/ Numbness/ Tingling/ Pinched Nerve/ Chronic Pain/ Paralysis

Multiple Sclerosis/ Parkinson's Disease

Reproductive:

Pregnant, due date _____ Ovarian/ Menstrual Problems/ Prostate

Skin

Rashes/ Cosmetic Surgery/ Athlete's Foot/ Herpes/ Cold Sores/ Open Sores

Digestive

Irritable Bowel Syndrome/ Bladder Infection/ Kidney Problems/ Colitis/ Crohn's Disease/ Ulcers

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Psychological

Anxiety/ Stress Syndrome/ Depression/ Mood Swings/ OCD/ Cold-sweats

Other Cancer/Tumors/Diabetes If yes, Location _____

Drug/Alcohol/Tobacco Use

Contact Lenses/Dentures/Hearing Aids

Any other medical condition(s) not listed: _____

Bodywork Experience

List you any specific medical condition or specific symptoms you have, bodywork may be contraindicated. A referral from your primary care provider may be required prior to service for insurance purposes.

Have you received bodywork before? _____ How recently?_____

What are your massage or bodywork goals?

_____

_____

_____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm

I understand that the massage "bodywork" I receive is provided for relaxation and Pain management. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and can be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination or diagnosis and that I should see a qualified medical specialist. Bodywork should not be performed under certain medical conditions, I affirm that I have Stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do So. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client agreement It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

Print name _____ D/O/B _____

Signature_____ Date _____

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