Bodywork Intake Form

General Information

Name: _____ Date: _____

Home: _____ Cell: _____ Work: _____

Address: _____ City/State: _____ Zip: _____

E-mail: _____ Referred by: _____

DOB: _____ Sex: M F Other: _____

Emergency Contact Name: _____ Phone: _____

If you were referred by another healthcare provider please fill out the Referral Information section. If you have not been referred by a provider but are curious about insurance reimbursement or coverage, please ask your therapist

Bodywork Information

Have you ever received a professional bodywork/massage session before? Yes ☐ No ☐

If yes, how often? _____

Have you received various types of bodywork (e.g. ashiatsu, reflexology)? Yes ☐ No ☐

Occupation: _____ Are repetative motions involved? _____

How often do you exercise? Daily ☐ Frequently ☐ Occasionally ☐ Never ☐

How often you you stretch? Daily ☐ Frequently ☐ Occasionally ☐ Never ☐

Are you sore after you exercise or stretch? Always ☐ Sometimes ☐ Never ☐

What is your primary area of complaint? _____

When did the above symptom(s) start? _____

Is the pain constant, intermittent, or does it appear after activity? Constant ☐ Intermittent ☐

After Activity ☐ After what types of activity? _____

Circle the quality of pain: Stabbing Aching Sharp Burning Dull
Tingling Throbbing Cramping Numbness Stiffness Swelling Shooting

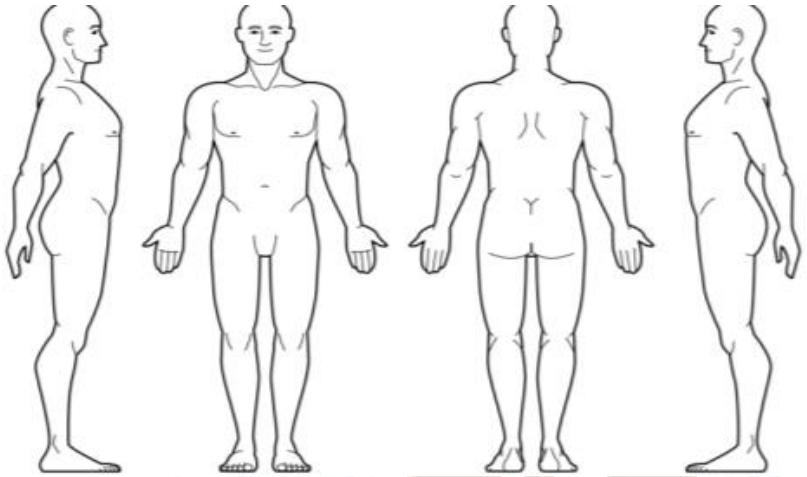
Other: _____

Does this pain interfere with any of the following: sleeping working recreation
daily activities other:_____

Have you ever been treated by another provider for this condition? Yes ☐ No ☐

Name/Title:	Name/Title:
Phone/Email:	Phone/Email:
Address:	Address:

Please circle any and all areas of discomfort:



On a scale of 1through 5, with 5 being the deepest, what is your preferred pressure?___

Are head, face, abs, glutes, and feet okay to work on? _____

Do you have any areas you do **not** want worked on? _____

_____

What is your preferred level of **conversation** during your session?

I like to talk ☐ Some, but I will lead the conversation ☐ Silent ☐

__please note__, your therapist will occasionally check in about pressure and comfort level

Medical Information

Do you take any medication(s) and or vitamin(s)? If so, please list: _____

_____

Do you have any contagious or infectious diseases? Yes ☐ No ☐

If yes, please explain: _____

Recent Surgeries? Please list: _____

Are you currently:

Pregnant? Yes ☐ No ☐

Nursing? Yes ☐ No ☐

Are you wearing:

Dentures? Yes ☐ No ☐

Contacts? Yes ☐ No ☐

Hair piece? Yes ☐ No ☐

Circle the conditions that apply to you: High/Low Blood Pressure Cancer Asthma Headaches/Migraines Arthritis Diabetes Stroke Heart Conditions Blood Clots Kidney Problems Skin Conditions Varicose Veins Epilepsy Neurological Disorders Psychological Disorders Brain Injuries Bruise Easily Endocrine/Thyroid Conditions Chronic Pain Sprains/Strains Broken Bones Spinal Injuries Joint Replacements Swelling Numbness Tingling

Referral Information

Do you have a [physician] referral/prescription? Yes ☐ No ☐

Is this related to an auto accident or workman's compensation claim? AA ☐ WC ☐ Neither ☐

Provider Name: _____ Title: _____ (e.g. DC)

Phone (office): _____ Phone (direct): _____

Are you seeking insurance reimbursement? Yes ☐ No ☐

If yes, please complete the ***Billing Information Form***

Type of insurance coverage for this claim: Major Medical ☐ Auto Accident ☐

Workman's Compensation Claim ☐

Is there anything, other than what is listed above, that you feel we should know about you, your health, or any other information? _____

_____

_____

Treatment Consent

Please read, and print your name and initials. Your signature and initials validate your responsibility now, and in the future, to share any additional, important, changed, and or related health information with your practitioner:

I, [***print name***] _____, have stated any and all conditions listed above are accurate to the best of my knowledge. I, [***initial***] ____ will inform my healthcare provider(s), including

my practitioner, about any changes, additions, and so forth about my health status and wellbeing. If I, [***initial***] ____ experience any pain, discomfort, or feel uncomfortable in any way, I will immediately inform the practitioner so said issues are remedied to suit my comfort level. I, [***initial***] ____ understand that massage/bodywork is not a substitute for medical diagnoses, examination, and or treatment and I should see my appropriate health care provider for services out of the scope of practice of my practitioner. I, [***initial***] ____ agree and understand that the practitioner assumes no liability should I fail to inform my practitioner of any updated changes to my medical file. I, [***initial***] ____ agree and understand any verbal, physical, or sexual conduct constitutes harassment and abuse and is not tolerated, and I may be prosecuted according to state or federal law. I, [***initial***] ____ understand my practitioner, and the establishment, are not liable for any unforeseen health changes or injuries sustained before, during, or after my treatment, and I assume all risk and responsibility. I, [***initial***] ____ understand that if I make any false allegations or claims against my practitioner, the establishment, and or their profession I may be prosecuted according to state or federal law. I understand my signature below affirms I have read and understand the information above and give my consent and authorization to receive treatment from this date onward.

Signature: _____ Date: _____

Therapist: [*print*]_____[*sign*]_____ Date: _____

Minors: The information above applies to minors and their parents or guardians. The parent/guardian giving authorization is responsible for the said minor and assumes the responsibility of making sure that minor feels safe. By law, no one under 18 years of age will be treated without a parent or guardian present at all times. No action will be taken against the practitioner or the establishment – all responsibility and liability lies on the person who signs this authorization.

Signature of Parent/Guardian: _____ Date: _____

Signature of Minor: _____ Date: _____

Therapist: [*print*]_____[*sign*]_____ Date: _____