



CONFIDENTIAL HEALTH HISTORY

Welcome! We want to make your time with us as pleasant and comfortable as possible.

If you have any questions or concerns regarding your appointment, please let us know as soon as possible. We look forward to working with you!

— PLEASE PRINT OR WRITE CLEARLY THANK YOU! —

LAST NAME FIRST NAME MIDDLE INITIAL TODAY'S DATE

MAILING ADDRESS CITY STATE ZIP

E-MAIL ADDRESS Yes, please send me periodic e-mail updates and specials. (I may un-subscribe at any time.)

Please mark () your preferred contact number for appointment reminders, etc.

HOME PHONE CELL PHONE WORK PHONE

Please list carrier for text/SMS notifications: _____

DATE OF BIRTH AGE* Male Female MARITAL STATUS: _____

*Signed parental consent required if under 18

OCCUPATION EMPLOYER

HOW DID YOU HEAR ABOUT US? Gift Certificate Facebook Yelp Cinema Video Commercial

Medical referral from: _____ Other (specify): _____

ARE YOU PREGNANT? NO YES / Due Date: _____

Name of Prenatal Caregiver / Physician: _____

CURRENT MEDICATIONS OR SUPPLEMENTS? NO YES (please list below):

DO YOU HAVE ANY ALLERGIES? NO YES (please list below):

EMERGENCY CONTACT: _____

Name / Relationship

Telephone

The Bodyworks Massage Center, Confidential Health History (Cont.)

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?:

- | | | |
|--|--|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Colitis / IBS |
| <input type="checkbox"/> Anxiety or Depression | <input type="checkbox"/> Joint ache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis, bursitis or gout | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sprains | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Staph Infection |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Athletes Foot |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Decreased range motion | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Surgery _____ |
| <input type="checkbox"/> OTHER / NOTES: _____ | | |

Please Indicate Your Consumption Level:

	None	Light	Moderate	Heavy
Salt:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU BEING TREATED FOR ANY OF THE ABOVE CONDITIONS?

- NO YES (Describe): _____

DO ANY OF THE FOLLOWING APPLY TO YOU TODAY?

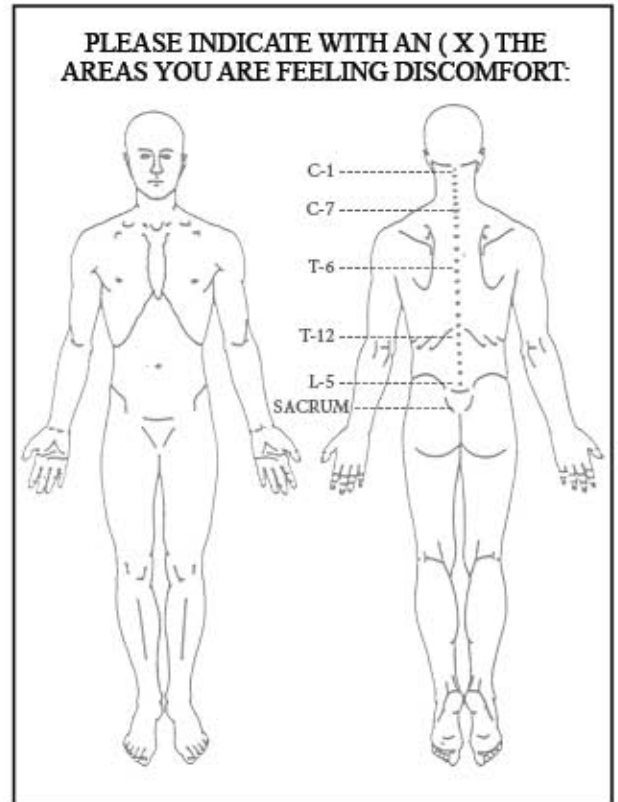
- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Wearing contact lenses | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Cold, flu, fever |
| <input type="checkbox"/> Open cuts, bruises, burns | <input type="checkbox"/> Sunburn | <input type="checkbox"/> Headache/Migraine |
| <input type="checkbox"/> Irritated skin / rash | <input type="checkbox"/> Severe pain | <input type="checkbox"/> Incontinence (Bladder/Bowel) |
| <input type="checkbox"/> OTHER (prosthesis, blood clot, etc.): _____ | | |

- Pain medication. If yes, what? _____

WILL THIS BE YOUR FIRST MASSAGE? YES NO

If NO, how long since your last massage? _____

WHAT ARE YOUR GOALS/EXPECTATIONS FOR TODAY'S SESSION?



PLEASE READ THE FOLLOWING AND SIGN BELOW:

I confirm that the above information is true to the best of my knowledge and understand that massage therapy is not a substitute for medical care and that no diagnosis will be made. • I hereby give consent for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice. • I understand that payment is due when services are rendered and that I am responsible for paying for any missed appointment(s) or any appointment(s) not cancelled as explained in our **APPOINTMENT POLICY**. → →

APPOINTMENT POLICY

We require 24-HOURS NOTICE to cancel or reschedule an appointment. • Failure to honor this policy will result in a CANCELLATION FEE OF 50% of the value of your service. • Neglecting to call us to cancel an appointment will result in a NO SHOW FEE OF 100% of the value of your service. • Exceptions will be made for emergencies and inclement weather. • We reserve the right to require Credit Card or Gift Certificate info to hold appointments. • *Thanks for your cooperation!*

SIGNATURE

DATE

*PARENT / GUARDIAN Signature (if applicable)

Printed Name & Relationship

Date