Body Works Wellness Center - Initial Health History Intake

Patient Contact Information

Patient Name: ______________________________________ Date: ________________

Date of Birth: ____________ Gender: ____________ Occupation: _____________________________

Address: ____

Phone: ____ Email: _____________________________

Referred by: ___________________ Emergency contact: ____________________________________

Physician/Health-care Provider name: __________________________ Phone: ___________________

Is massage/bodywork medically necessary (is it for a medical condition, injury, surgery) Yes ☐ No ☐

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

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Previous Massage, Facilitated Bodywork and Manual Therapy

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

How recently and why? ____

What types of massage/bodywork do you prefer? ____

What kind of pressure do you prefer? Light Medium Firm

List the medications you currently take and reasoning

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Are you wearing contacts?	**Yes ☐ No ☐**	**Are you wearing a hairpiece?**	**Yes ☐ No ☐**
Are you wearing dentures?	**Yes ☐ No ☐**	**Are you currently pregnant?**	**Yes ☐ No ☐**

Have you had any injuries or surgeries in the past?

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Circle any of the following health conditions that you currently have:

blood clots – infections - congestive heart failure - contagious diseases - pitted edema

**Please answer honestly, Manual Therapy can be dangerous or even life threatening if any of the above conditions are present.*

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain ______________________________
Current	Past	Muscle or joint stiffness ______________________________
Current	Past	Numbness or tingling ______________________________
Current	Past	Swelling ______________________________
Current	Past	Bruise easily ______________________________
Current	Past	Sensitive to touch/pressure______________________________
Current	Past	High/Low blood pressure ______________________________
Current	Past	Stroke, heart attack ______________________________
Current	Past	Varicose veins ______________________________
Current	Past	Shortness of breath, asthma ______________________________
Current	Past	Cancer______________________________
Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain) ________________
Current	Past	Epilepsy, seizures ______________________________
Current	Past	Headaches, Migraines ______________________________
Current	Past	Dizziness, ringing in the ears ______________________________
Current	Past	Digestive conditions (e.g. Crohn's, IBS) ________________
Current	Past	Gas, bloating, constipation ______________________________
Current	Past	Kidney disease, infection ______________________________
Current	Past	Arthritis (rheumatoid, osteoarthritis) ________________
Current	Past	Osteoporosis, degenerative spine/disk ________________
Current	Past	Scoliosis ______________________________
Current	Past	Broken bones ______________________________
Current	Past	Allergies ______________________________
Current	Past	Diabetes ______________________________
Current	Past	Endocrine/thyroid conditions ______________________________
Current	Past	Depression, anxiety ______________________________
Current	Past	Memory Loss, confusion, easily overwhelmed________________

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the application/approach may be adjusted to be conducive for me. I further understand that facilitated bodywork/massage should not be utilized as a substitute for medical examination, or diagnosis and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that bodywork/massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because bodywork/massage should not be performed under certain physical/medical conditions, I affirm that I have stated all my known physical/medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my physical/medical profile and understand that there shall be no liability on Body Works Wellness Center, or the Licensed Massage Therapists 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. Understanding all of this, I give my consent to partner with my practitioner for facilitated manual therapy care.

Patient Signature: ____Date: ____________

Parent or Guardian Signature (in case of a minor): ________________________ Date: ____________