

Bodyology Therapeutics

medical massage ~ intrinsic healing

Intake Form – page 1 of 2

NAME: _____ DATE: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____ AGE: _____

ADDRESS _____

CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL _____

EMAIL: _____

EMERGENCY CONTACT NAME & PHONE: _____

WHO REFERRED YOU TO THIS OFFICE?: _____

DESCRIBE MAJOR COMPLAINT: _____

WHEN AND HOW DID YOUR CONDITION DEVELOP?: _____

WHAT MAKES YOUR CONDITION WORSE?: _____

LIST DIAGNOSIS(IF KNOWN) AND CURRENT TREATMENT: _____

IF AUTO ACCIDENT GIVE DATE AND DESCRIPTION: _____

ALL SURGERIES & SERIOUS ILLNESSES: _____

ARE YOU CURRENTLY UNDER A DOCTORS CARE: N Y (PLEASE EXPLAIN) _____

LIST ALL MEDICATIONS AND THEIR PURPOSE: _____

ARE YOU TAKING BLOOD THINNERS: Y N NAME _____

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Do you have any skin disorders or allergies? N Y - Please explain: _____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y

Do you smoke? N Y - how much? _____

Do you drink alcoholic beverages? N Y - how much? _____

Are you pregnant? N Y - estimated due date? _____

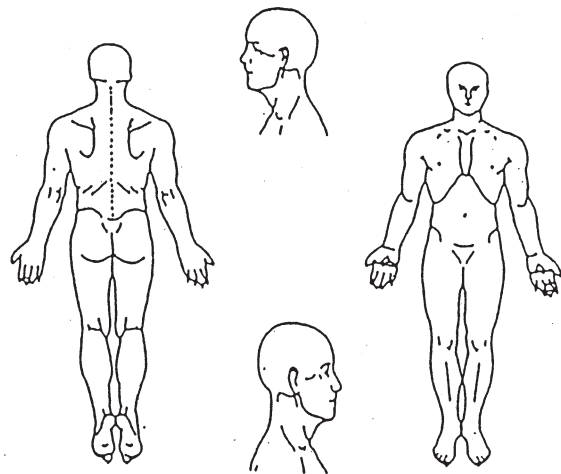
Are you participating in regular fitness program? N Y - please describe: _____

Do you have any other medical condition or physical limitation that your therapist needs to know before you receive this bodywork? N Y - Please explain: _____

Please check any of the following conditions that apply, present or past, to you:

- | | |
|--|--|
| <input type="checkbox"/> AIDS (or HIV related) | <input type="checkbox"/> Severe Irritability |
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> severe Depression |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Severe Menstrual Pain |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Stomach Disorders | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Foot Numbness |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Foot Pain |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Elbow Pain |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hand Numbness |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Hands Cold |

PLEASE SHADE IN ALL AREAS OF PAIN



I have listed ALL my known medical conditions, physical limitations, and medications. I will inform my therapist of any changes in my physical health or medications. I understand that a licensed massage therapist neither diagnoses illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

In the event that I cannot make a scheduled appointment, I understand it is my responsibility to cancel at least 24 hours in advance (barring emergencies), or else I will be responsible for paying for that time.

I understand the information contained herein is privileged and confidential, and I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

Signature: _____ Date: _____

If a minor, signature of parent/guardian: _____