Client Information for Bodycentric Healing Arts

Name:_____
Address: _____
City: _____ State:_____ Zip Code:_____
Home #:_____ Work #: _____ Cell #:_____
May we call you at home? YES/NO work? YES/NO cell? YES/NO
May we leave messages for you at home? YES/NO

E-mail address: _____
How did you hear about us?_____
In case of emergency: _____ Phone: _____
Your Occupation: _____

Age: ___Date of Birth: _____Sex:_____ Gender: _____
Please list any other medical practitioners seen: _____
Primary Care Physician _____ Specialist _____
Chiropractor _____ Physical Therapist _____
Acupuncturist _____ Nutritionist _____
Bodyworker _____Others_____

Have you ever experienced a professional massage or bodywork session? Yes/No
If yes, how recently? _____
Primary reason for this appointment:_____
_____
If the above condition is related to an accident or injury, please describe the incident briefly and when it occurred._____
_____
Does the above condition interfere with your work? YES/NO Sleep? YES/NO Recreation? YES/NO
Are you pregnant? YES/NO
What goals are you looking to attain from your session?

Do you exercise? YES/NO Type of exercise & How often? _____
_____
Do you wear contact lenses? YES/NO dentures? YES/NO hearing aid? YES/NO
Do you have any other medical condition(s) that the therapist should be aware of prior to administering any form of massage/bodywork? YES/NO
If yes, please specify: _____
Are you currently taking medication? If so, please list:
_____
_____

Please check any of the following conditions that you are currently experiencing or have recently experienced:

MUSCULO-SKELETAL

___Arthritis
___Osteoporosis
___TMJ dysfunction
___Sciatica
___Herniated disc
___Other spine problem(s)
___Bursitis
___Tendonitis
___Other

CIRCULATORY

___Varicose veins
___Blood clots
___High blood pressure
___Low blood pressure
___Phlebitis
___Arteriosclerosis
___Aneurysm
___Easy bruising
___Heart condition
___Other

DIGESTIVE

___Constipation
___Ulcerated Colon
___Spastic Colon
___Abdominal pain
___Stomach ulcer
___Other

MISC.

___Cold hands/feet
___Numb hands/feet
___Headaches
___Migraine headaches
___Fatigue
___Fainting
___Cold or flu
___Shortness of breath
___Severe depression
___Sensitivity to lotions
___Asthma
___Cancer
___Skin condition(s)
___Dizziness
___Recent surgery
___Nerve pain
___Insomnia
___Hepatitis
___Recent internal bleeding
___Diabetes
___Other

FEMALES

___PMS
___Menstrual cramps
___Current pregnancy
___Other

I understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any medical or physical ailment of which I am aware. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature _____ Date_____
Practitioner Signature_____ Date_____

Consent to Treatment of a Minor: By my signature, I hereby authorize BodyCentric Healing Arts to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian_____ Date_____