BodyWorks Therapeutic Massage LLC
Confidential Client Information

Please print all information clearly:

Name: ______________________________ Date of Birth: ____________

Physical Address: ____

City: ______________________ State: __________ Zip: ____________

Mailing Address: ____

Home Phone: ____________ Cell Phone: ______________ Work Phone: ______________

Email: ____

Emergency Contact: ____________________ Emergency Phone: ______________

Referred by: __________________________ Phone: ______________________

In an effort to save paper and postage we prefer to send communications via email whenever possible. We do not wish to overload your inbox with email, and you will always have the opportunity to change or opt out of your communication preferences.

May we email appointment reminders*?	☐ Yes, Please!	☐ No, Thanks!
May we send a Birthday Gift?	☐ Yes, Please!	☐ No, Thanks!
May we send occasional announcements?	☐ Yes, Please!	☐ No, Thanks!

***PLEASE NOTE:** We no longer provide reminder calls by telephone and highly recommend allowing appointment confirmations and reminders by email to avoid incurring a missed appointment fee.

Please take a moment to carefully read and complete the following information and sign where indicated. **This confidential information is important and necessary in consideration of your safety and health goals.** If you have questions about the requested information, please discuss them specifically with your practitioner **PRIOR** to receiving services. If you have a specific medical condition or specific symptoms, certain services or therapies may be contraindicated and a referral from your primary care provider may be required prior to service being provided.

☐ Male ☐ Female Age: _________ Height: _______________ Weight: _____________

Occupation: ____

Hobbies, Sports or Other Regular Activities: ____

So that we may better understand your current healthcare situation, please indicate all medical and other healthcare practitioners you are seeing: ____

If you answer "yes" to any of the following questions, please explain as clearly as possible:

☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Do you have high / low blood pressure?
☐ Yes ☐ No Do you take meds for high blood pressure?
☐ Yes ☐ No Do you have any respiratory conditions?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you experience headaches?
☐ Yes ☐ No Do you experience dizziness?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Are you pregnant? Due date: _____________
☐ Yes ☐ No Do you suffer from arthritis or joint swelling?
☐ Yes ☐ No Have you been diagnosed with cancer?
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you currently have a contagious condition?

In the past 2 years, have you:
☐ Yes ☐ No Had any broken bones or other injury?
☐ Yes ☐ No Had surgery?

☐ Yes ☐ No Do you have allergies or sensitivity to latex or skin care products?
☐ Yes ☐ No Do you have problems sleeping?
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Do you have numbness or stabbing pains?
☐ Yes ☐ No Do you have tension or soreness in any specific area?
☐ Yes ☐ No Do you have any other medical condition that we should know about? Please explain below.

Please list all medications/supplements and provide any comments/explanations: ____

☐ I understand that services provided by BodyWorks should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment.

☐ I understand that BodyWorks practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

☐ Because some treatments should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions, current medications, and have answered all questions honestly. I agree to keep BodyWorks updated as to any changes in my medical profile and understand that there shall be no liability on the part of BodyWorks or the practitioner should I fail to do so.

☐ I understand that if I cancel a session with less than 24 hours notice, I may be required to pay for the session.

☐ I understand that BodyWorks does not extend credit, and all session fees are due at the time of service. In the event that my account is turned over to a third party for collection, I understand that I am responsible for appointment fees; returned check fees; attorney, legal and collection fees; and interest accrued at 21% from the date service was provided.

Client Signature: ______________________________ Date: ______________

Practitioner Signature: ______________________________ Date: ______________

Parent/Legal Guardian (if under 18) ______________________________ Date: ______________