Tri Balance Bodywork LLC

NAME: _____DATE: _____

ADDRESS/ZIP: _____

MOBILE PHONE: _____ ALTERNATE PHONE: _____

EMAIL: _____ DOB: _____

EMERGENCY CONTACT: _____

-MOBILE PHONE: _____ ALTERNATE PHONE: _____

HOW DID YOU HEAR ABOUT ME? _____

OCCUPATION: _____

ACTIVITIES/HOBBIES: _____

EXERCISE/STRETCHING (type/times per week): _____

HEALTHCARE PROVIDERS: _____

Have you received professional bodywork? (massage, energy, alternative, etc.) _____

What is the purpose of your visit today? _____

GENERAL HEALTH

ALLERGIES: _____

CAR ACCIDENTS/DATES: _____

SURGERIES/DATES: _____

Musculoskeletal System

_____Neck pain _____Upper back pain _____Mid- back pain _____Low back pain
_____Shoulder pain R/L _____Arm pain R/L _____Elbow pain R/L _____Wrist pain R/L
_____Hip pain R/L _____Leg pain R/L _____Knee pain R/L _____Ankle pain R/L
____Broken bones – Location: _____ ____Ligament sprains – Location: _____
____Torn muscles – Location: _____ ____Muscle strains – Location: _____
____Joint pain – Location: _____ ____Arthritis – Location: _____
Other: _____

Nervous System

_____Dizziness or Vertigo _____Seizures/Epilepsy _____Loss of coordination
_____Loss of balance _____Frequent Headaches or Migraines
_____Frequent Muscle Twitching, tics or spasms – Location: _____
_____Numbness/tingling – Location: _____
Other: _____

Respiratory System

_____Frequent shortness of breath _____Chronic/frequent coughing
_____Regular Colds or Infections _____Pain on breathing
Other: _____

Cardiovascular System

_____Pacemaker _____Stroke _____Varicose veins
_____Neuritis/Neuropathy _____Phlebitis/Thrombosis _____High/low blood pressure
Other: _____

Gastrointestinal System

_____Frequent Constipation _____Frequent cramps _____Frequent heartburn
_____Frequent diarrhea _____Frequent indigestion or gas
_____Abdominal pain _____Liver/Gall Bladder _____ Ulcers
Other: _____

Head, Mouth & Throat

_____Dental crowns, bridges, mouth work _____Trouble swallowing
_____Grinding of teeth, TMJ, Clicking Jaw _____ Braces (current or history)
_____Vision problems _____Hearing problems/Earaches
_____Contacts _____Tinnitus
Other: _____

Reproductive System

_____Menopause or peri-menopausal symptoms _____Fibroids, cysts, or endometriosis
_____Frequent cramping _____Irregular cycle _____C-section
Other: _____

Endocrine/Lymphatic/Urinary Systems

_____Glandular Dysfunction – Type: _____
_____Fluid Accumulation/Swelling – Location: _____
_____Urinary Retention _____Kidney Disease
Other: _____

SPECIFIC CONDITIONS AND TREATMENTS

CANCER Diagnosis and Date: _____
Lymph Node Removal/location: _____
RADIATION/date of last treatment: _____ CHEMOTHERAPY/date of last treatment: _____

DIABETES: _____ Insulin? _____ DEPRESSION/ANXIETY-meds: _____
AUTOIMMUNE DISEASE: _____
SKIN CONDITIONS: _____
INFECTIOUS DISEASES: _____
Other: _____

POLICY STATEMENT FOR CLIENTS

Missed or rescheduled appointments with less than 24 hours' notice are subject to a fee up to the full amount of the session. I recognize that you might have an emergency or need to change your plans occasionally.

If you are late for your appointment, I will still end at the normal time so as not to make all subsequent patients late for their appointments.

Services are paid for at the time they are provided unless other arrangements are made in advance.

I agree to keep my 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.

I provide professional services for relaxation or therapeutic changes in the body. Total draping is used in this office to provide privacy, respect and a sense of comfort. As such, this is a health care practice; sexual innuendo or inferences will not be tolerated by the therapist.

Please Sign below as an indication that this form is accurate and understood on all sides and as an acknowledgement that you have received and carefully read a copy of the HIPPA Notice of Privacy Practices provided to you by my office or on my website. MA 40547 MM 34742

Client Signature: _____ Date: _____