Copacetic Bodyworks Medical Intake

Name _____ Today's Date _____

Home Address _____City/ Zipcode _____

Local/Rental Address_____City/Zipcode_____

Local Phone _____ Home Phone _____

Cell Phone _____ Work Phone _____

Email Address _____ Birthdate _____

Emergency Contact Name/Phone Number _____

Physician Name/City/Phone Number _____

Occupation/Hobbies/Sports that might affect your musculature _____

Please CIRCLE any of the following you have or have had:

Bone/joint disease
Broken/Cracked Bones
Sprains/Strains
Dislocations
Head Injury
Neck/Spinal Pain/Injury
Numbness/Tingling
Amputations
Sciatica
Muscle Spasms/Cramps
Prostate Disease
High Blood Pressure
Substance Abuse_____
Atherosclerosis
Varicose Veins
Anxiety/Nervousness
Blood Clots
Fibromyalgia
Fatigue

Heart Disease
Irregular Pulse
Breathing Difficulty
Lung Disease
Jaw discomfort/TMJD
Headaches/Type_____
Multiple Sclerosis
Parkinson Disease
Kidney Disease
Bladder Disease
Pregnancy #_____
Bowel Disease
Low Blood Pressure
Arthritis/Type_____
Insomnia
Bruise Easily
Bursitis
Edema/Swelling
Rheumatism

Allergies/Fungus
Skin Disorder
Vision Impairments
Hearing Impairment
Asthma
Diabetes
Sinus Problems
Frequent Colds
Localized Infection
Stroke
Herpes/Type_____
Irreg. Sleep Patterns
Digestive Disease
Lymphedema
Phlebitis
Tendonitis
Epilepsy/Seizures
Cancer/Type_____

Do you have any other medical condition(s) that the practitioner should be aware of before you receive a body work session? Yes ____ No ____ Please explain: _____

_____

Please let us know what and when for the following:

Surgery _____

Major Illness _____

Injuries/Accidents _____

Where is tension most evident in your body? _____

How often do you experience this stress? _____

How intense is this stress? _____

How long have you experience this stress? _____

How much water do you drink daily? _____

List any medications/drugs/supplements you are taking and how long?

_____

_____

What position do you sleep in? _____

What position is most common for you? (sitting- at desk, computer, in recliner, standing, lying down, etc.) _____

Have you ever had a therapeutic massage, reflexology session, lymphatic drainage session?

Yes ___ No ___ If so, how long ago? _____

Have you had or are you currently receiving other body work? Yes ___ No ___

If so, what kind? _____

Who may I thank for your referral? _____

This is your session. Please feel free to state your preferences that will make it more comfortable for you. Thank You

RELEASE

I, _____, understand that this session is for the purpose of stress reduction, relief from muscular tension or spasm, for increasing circulation and energy flow or _____.

I understand that the practitioner does not diagnosis illness, disease, or any other physical or mental disorder. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor does she/he perform any spinal manipulations. It has been made clear to me that this session is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician or health care practitioner for any physical ailment(s) that I might have.

Because the practitioner must be aware of existing physical conditions, I have stated all my know medical conditions, and answered all questions honestly. I agree to keep the practitioner updated on my physical and mental health.

POLICIES

In fairness to other clients and the practitioner, a 24-hour notice is required for cancellation of your appointment. If we do not receive timely notice, you will be charged the amount of your scheduled appointment. You will be required to pay this fee before another appointment is scheduled.

If you are ill please call and cancel your appointment. You will not be charged a fee for this service. As a health and wellness facility we strive to keep our rooms clean and relatively germ-free. You can help us by canceling your appointment if you are not feeling well. A 24-hour notice is greatly appreciated.

Please be on time for your appointment. If you arrive late your time will not be extended.

We accept cash or check for services only.

Please do not wear fragrances (cologne, perfume, essential oils, cigarette odor) in consideration of any allergies the therapist or other clients might have.

If you must use the restroom during the session, please put your shoes on prior to leaving the therapy room. BARE FEET are not permitted outside the therapy room per health regulations.

I have read and understand the policies and release outlined in this agreement.

Signature _____ Date _____
Practitioner Signature _____ Date _____

COPACETIC bodyworks

COMMUNICATION FORM

Name: _____

Below, please list the best way to contact you.

___ By Telephone
Green Valley Home: _____
Out of State Home: _____
Cell: _____
A message may be left at this number: Yes ___ No ___

Best times to be contacted:
Earliest hour: _____
Latest hour: _____

___ By Text:
Telephone number: _____
Earliest hour: _____
Latest hour: _____

___ By Email:
Address: _____