

Bodymind

26 B Baltimore Avenue, Rehoboth Beach, DE 19971
32191 Nassau Road, Unit 3, Lewes, DE 19958
(302) 226 8833

A. Personal Data and Health Information

(Please complete both sides)

Name: _____ Date: _____

Address: _____

Phone:(_____) _____ e-mail _____

Date of Birth: _____

How did you hear about Bodymind? _____

Are you currently under medical care or supervision? For what condition?

Are you currently taking any medication? If so, what?

What is your main area of pain/ concern?

What aggravates it?

What relieves it?

Please identify all current (C) or past (P) health conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Hypertension/ High BP | <input type="checkbox"/> Pregnancy/ Now | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Athlete's Foot/ Plantar Warts |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Skoliosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Numbness/ Tingling |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tendonitis/ Bursitis |

Surgeries: _____

Herniated Disc: Where? _____

Fractures/ dislocations: Where? _____

Allergies: _____

Other: _____

This information will be treated confidentially.

I have read the above information and discussed it with my practitioner. I understand that massage therapy does not constitute medical treatment and is not a substitute for medical examinations and/or diagnosis. It is a form of health and wellness maintenance utilizing the techniques of traditional massage. I take responsibility for alerting my practitioner to any physical conditions that would affect this work.

Signature: _____ Date: _____

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B. Office Policies

Payment For Services

We accept cash, personal check, VISA, Master Card, Discover, American Express
Payment is due at the time of service unless other arrangements have been made.

Cancellations

Cancellations must be made 24 hours in advance of the scheduled appointment time. If cancellations are not made within 24 hours, payment in full is required. This charge will be waived if a replacement can be found for your appointment time.

Right of Refusal

I reserve the right to refuse service to anyone. This includes but is not limited to anyone who requests treatment or services that are outside my scope of practice. I will exercise this right if anyone arrives for treatment under the influence of alcohol or recreational drugs or presents sexual intentions. I reserve the right to charge for the session time under these circumstances, whether or not services were rendered, if I so choose.

Client Agreement

I have read the policies stated above and agree to abide by them.

Signature: _____ Date _____

Notes: