bodworks
PHYSICAL THERAPY

MASSAGE THERAPY
REGISTRATION & RELEASE FORM

3161 43rd St S • Fargo, ND 58104
Phone: (701) 893-2639
Fax: (701) 893-2638
www.bodyworksfargo.com

Client Name: (print) _____ Date of Birth: _____ Age: _____
First Name, MI, Last Name

Responsible Party: (if minor) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

E-mail Address: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____ Alternate Phone: (_____) _____

Reason for Visit: _____ Referred By: _____

Please take a moment to carefully read the following information and sign where indicated.

- ☐ I understand that this information will be treated confidentially.
- ☐ In order to maximize the effectiveness and safety of massage sessions, I agree to give feedback during and at the end of my sessions.
- ☐ I understand that I will need to update my therapist on my health and wellness prior to each session.
- ☐ I understand that the massage/bodywork I receive is provided for the relief of muscular tension and soreness. If I experience any pain or discomfort during this session, I will immediately inform the therapist.
- ☐ I further understand that massage/bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any physical or mental ailment of which I am aware.
- ☐ I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or emotional conditions and that nothing said during the course of treatment should be construed as such.
- ☐ I understand that payment is due in full after my massage and cannot be billed to me or my insurance.
- ☐ I understand, as a courtesy, that I need to give a 24-hour notice if I am unable to make it to my appointment.

Due to HIPAA and confidentiality requirements, we must ask the following questions. Please read and check the appropriate places.

It is okay to speak with or leave messages regarding my appointments with anyone at/on my (check all that apply):

☐ Home ☐ Work ☐ Answering Machine ☐ Voice Mail ☐ E-mail ☐ Facebook

Is there anyone that you ***do not*** want us to leave a message with regarding appointments?

☐ No ☐ Yes, Please List: _____

It is okay to discuss any medical, scheduling and/or billing information with the following people: _____

_____

_____ _____ _____

PRINT NAME ***SIGNATURE*** ***DATE***

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HEALTH & WELLNESS FORM

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Please review this list and check any illness and/or medical conditions which apply currently or in the last five years.

- ☐ Acne
- ☐ Allergies
- ☐ Arthritis
- ☐ Back Pain
- ☐ Bruise Easily
- ☐ Cancer or Tumors – what type?_____ is it in remission?_____
- ☐ Carpal Tunnel
- ☐ Chronic Fatigue
- ☐ Constipation
- ☐ Diabetes – what type?_____
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Edema
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Infectious Conditions
- ☐ Insomnia
- ☐ Kidney Disorders
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Pregnancy – what trimester?_____
- ☐ Ruptured/Bulging Disc – where?_____
- ☐ Seizures
- ☐ Skin Rashes
- ☐ Stroke – date(s)?_____
- ☐ Thyroid Disorder (hypo – hyper)
- ☐ TMJ Disorder
- ☐ Varicose Veins or Blood Clots
- ☐ Other:_____

Do you wear: ☐ Hearing Aids ☐ Contact Lenses ☐ Dentures ☐ Pacemaker

List any injuries ***not requiring surgery*** that occurred within the past 2 years (broken bones, torn ligaments, auto accident, etc.)

List all medications you currently take (include over the counter medications as well as vitamins/herbs) _____

Are you sensitive to touch in any areas? ☐ YES ☐ NO If yes, please list:

What type(s) of exercise do you engage in regularly? _____

Is stress affecting your health and wellness? ☐ YES ☐ NO If yes, please describe:

Circle the number which best describes your current level of stress:

(Low) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 (High)

Circle the number which best describes your current level of health:

(Low) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 (High)

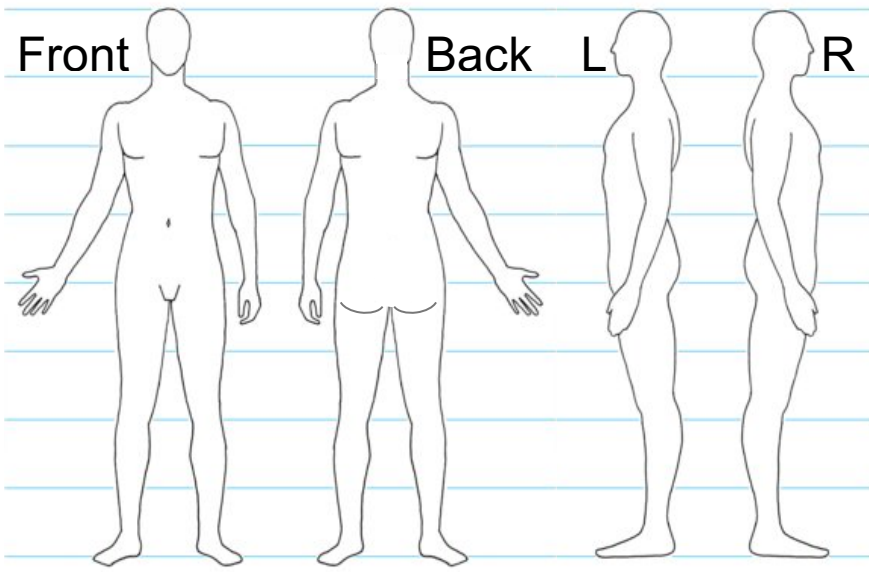
Is one of your goals in receiving massage to reduce the adverse affects of stress? ☐ YES ☐ NO

If you are having problems in specific body areas, write a list below with the indications next to them

N = numbness

T = tingling

ST = stiffness
S = soreness
P = pain
A = ache



What is your primary complaint? ____

_____

_____