Bodymind
26 B Baltimore Avenue
Rehoboth Beach, DE 19971

PERSONAL INFORMATION

Name_____Date_____
Address_____
_____
Phone _____**E**mail_____
Date of Birth_____
How did you hear about Bodymind?_____

What is your main area of concern? _____
Are you presently under medical care? For what?_____
Please list current medications:_____
_____

MEDICAL HISTORY. Please mark **C** for current or **P** for past

___ Headaches	___ Pregnancy Now. How many weeks?_____
___ Neurological *numbness or tingling / Multiple Sclerosis / other*	___ Stroke When?_____
___ Arthritis: *Osteo Rheumatoid Gout*	___ Epilepsy / Seizure Disorder
___ Asthma/ COPD/ Respiratory problems	___ Kidney problems
___ Blood Pressure *High Low Controlled*	___ Thyroid Problems: *Hyper / Hypo*
___ Cancer: Where: (Please complete section on following page)	___ *Blood Clot / Pulmonary Embolism / DVT* Where?_____ _____ When?_____
___ Swelling, edema. Where? _____ ___ Swollen lymph nodes. Where? _____	___ Infections / Chronic Diseases _____
___ Diabetes: *Controlled Uncontrolled*	___ Gastrointestinal Problems
___ *Sprains / Strains / Tendonitis* Where?_____	___ Osteoporosis
___ Heart Problems: ___ *Congestive Heart Failure: When*_____ ___ *Heart Attack:When?*_____ ___ *Bypass surgery/ Stents: When?*_____ ___*Pacemaker*	___ Herniated disc. Where?_____ ___ Fractures Where?_____ ___ Other injuries: _____ _____
___ Pain syndrome: ___ *RSD/ Chronic Regional Pain Syndrome* ___*Shingles* ___*Neuropathy Where?* ___*Fibromyalgia*	___ Surgeries. List type and date _____ _____ _____ _____
___ Circulatory Problems: *Arterial / Venous / Raynauds syndrome Varicose Veins*	___ Skin conditions *sensitive skin / rash / acne / athlete's foot/ other*_____
	___ Allergies _____

Any other health conditions that are not listed_____

please continue on 2nd side

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All statements on this form are true to the best of my knowledge. All information will be treated confidentially.

I understand that massage therapy does not constitute medical treatment and is not a substitute for medical examinations and/ or diagnosis. All treatments will be within the scope of the practice of massage therapy.

I understand that the therapist has the right to refuse service to anyone who requests treatment or services that are outside of the scope of practice of massage therapy, arrives for treatment under the influence of alcohol or recreational drugs or presents sexual intentions. The therapist reserves the right to charge for the session under these circumstances, whether services were rendered or not.

I understand that I am responsible for payment of treatment in full after each appointment and that 24 hours' notice is required to cancel or re-schedule any future appointments. A cancellation fee of half the regular cost of a session will apply if cancellations are not made at least 24 hours prior to the time of the appointment.

Signature_____ Date_____