Sanibel Wellness

MASSAGE/BODYWORK INFORMATION FORM

NAME: _____ **COMPANY** _____ **DATE** _____

LOCAL PHONE (___)_____ EXT____ **OCCUPATION** _____

OTHER PHONE (___)_____ ☐ Business ☐ Home ☐ Mobile

EMAIL _____ **WEBSITE** _____

LOCAL ADDRESS:

SUITE/APT# _____ **STREET** _____

CITY _____ **STATE** ____ **ZIP** _____ **TYPE** ☐ Home ☐ Business ☐ Seasonal Home ☐ Vacation

DATES OF RESIDENCY ☐ Annual ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

ALT. ADDRESS (OPTIONAL):

SUITE/APT# _____ **STREET** _____

CITY _____ **STATE** ____ **ZIP** _____ **TYPE** ☐ Home ☐ Business ☐ Seasonal Home ☐ Vacation

HEALTH INFORMATION

1) What is your birthdate? _____ 2) Do you exercise regularly? Yes__ No__

3) How would you describe your present health? Excellent__ Good__ Fair__ Poor__

4) Do you have any skin sensitivities, rashes, bruises, lesions or contagious diseases? No__ Yes__
If yes, please specify:

5) Are you allergic or sensitive to any herbs or scents? No__ Yes__
If yes, please specify:

6) Do you wear: contact lenses?__ hearing aid?__ dental prosthesis?__

7) What do you hope to gain by receiving massage/bodywork? Relaxation/Stress Relief__ Pain Relief__
Other (please specify):

8) Please comment on any health condition or other issue that pertains to your massage/bodywork:

9) How did you hear about us?

☐ Friend/Relative	☐ Professional Referral	☐ Yoga Class	☐ Benefit Event
☐ Resort/Hotel	☐ Walk-in	☐ Internet	☐ Mail/Email
☐ Phone Book	☐ Chamber of Commerce	☐ Newspaper/Magazine	☐ Other:

10) Would you be interested in receiving the Sanibel Wellness Email Newsletter?
☐ Yes ☐ No

Sanibel Wellness

HEALTH INFORMATION (CONTINUED)

NAME: _____ DATE _____

11) Please check any of the following that apply to you:

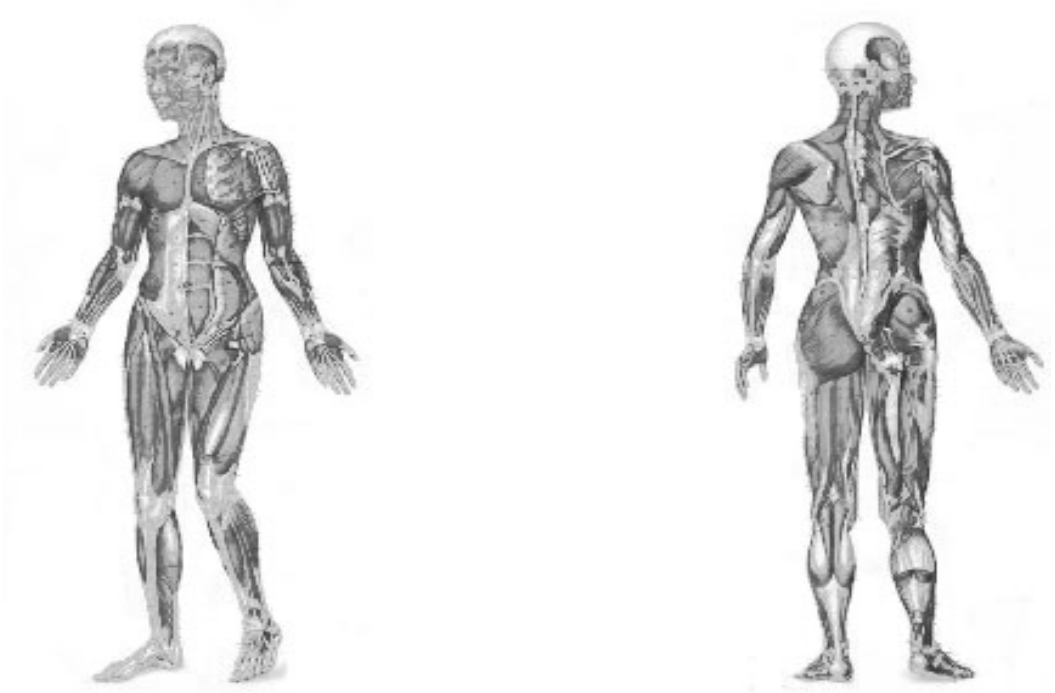
☐ High Blood Pressure	☐ Headaches or Migraines	☐ Anxiety
☐ Osteoporosis	☐ Skin Disorder	☐ Autoimmune Disease
☐ Kidney Disorder	☐ Heart Disease	☐ Fybromyalgia
☐ Bruise Easily	☐ Diabetes	☐ Phlebitis/Thrombosis
☐ Digestive Disorder	☐ Epilepsy or Seizures	☐ Chronic Pain (Specify):
☐ Sinusitis	☐ Varicose Veins	☐ Cancer (Specify):
☐ Arthritis	☐ Asthma	☐ Limited range of motion (Specify):
☐ Depression	☐ Are you pregnant?	☐ Other (Specify):

12) List any medications/vitamins/supplements you are currently taking:

13) List any pertinent prior surgeries or injuries:

14) Do you consume (mark (1) for light, (2) for moderate, (3) for considerable):
caffeine? (1)__ (2)__ (3)__ alcohol? (1)__ (2)__ (3)__ tobacco? (1)__ (2)__ (3)__

15) Using diagrams below, please draw an arrow to any area of your body where you presently experience pain, injury, disability or dysfunction.



16) Please read the following and initial below:

I understand that the massage/bodywork treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal adjustments or to diagnose any physical or mental illness, and that nothing said in the course of the session should be construed as such. All medical information is kept strictly confidential in accordance with HIPPA regulations. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Initials _____