**BODY AWARE THERAPY, LLC**
443-532-2547
www.bodyawaremfr.com

# Health Assessment Form

Name
Date
Age
Occupation

Email address
Best number to call

How did you hear about us?

Referred by

Primary reason for visit

Secondary reason for visit

Date symptoms began

Place an x for any medical conditions you have

| | | | |
|---|---|---|---|
| Circulatory issues | | Blackouts | |
| High blood pressure | | Visual disturbances | |
| Heart trouble | | Weight changes (>15 lbs) | |
| Pacemaker | | Headaches | |
| Epilepsy | | Ringing in the ears | |
| Diabetes | | bowel/bladder problems | |
| Pregnancy | | Malignancy | |
| Stroke | | Other | |

**Past medical history:** Please list any surgeries, traumas, accidents or other conditions and dates of occurrence.

**Medications:** Please list ALL medications you are currently taking and reason

**Please place a check mark in front of each item you experience monthly.**
Place an X in front of each item you experience weekly or more frequently.

| | | | |
|---|---|---|---|
| | Heart pounding or racing | | Worrisome thoughts |
| | Irregular heartbeat | | Thoughts of suicide |
| | Chest pain, tightness | | Feeling inadequate, unable to cope |
| | Numbness, tingling in arm or leg | | Uncontrolled crying or sadness |
| | Feeling coldness | | Voice quivering, shaking |
| | Coughing | | Eyes irritated |
| | Stuffy nose | | Eyestrain or discomfort |
| | Asthma or shortness of breath | | Nosebleeds |
| | Stiff or tender joints | | Stomach cramps |
| | Back problems | | Hearturn or indigestion |
| | Trembling, twitching muscles | | Constipation |
| | Skin rashes | | Menstrual difficulties |
| | Grinding of teeth | | Breast tenderness |
| | Difficulty sleeping though night | | Hot flashes |
| | Periods of extreme fatigue | | Alcohol abuse |
| | Feeling faint or dizzy | | Substance abuse |
| | Feeling tense or nervous | | Other: |

**Consent to Treat release Form**

1. If I experience discomfort during my session, I will immediately inform my therapists, so that the pressure/ strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

2. I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal adjustments, diagnose, prescribe or treat physical or mental illness

3. I affirm that I have notified my therapist of all known medical conditions, medications and injuries.

4. I agree to inform the therapist of any changes in my health and medical conditions and injuries.

5. I understand that massage and bodywork is entirely therapeutic and non-sexual in nature

6. I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to the fee of $45 payable before scheduling any further appointments.

Client Signature_____Date _____

Guardian Signature if client is a minor

_____