Breathe Easy Bodywork

Specializing in soothing stress and its effects

PERSONAL DATA and HEALTH SCREEN

Confidential

Name:_____ Date:_____

Address:_____

City_____ State_____ Zip_____

Phone:_____ Date of Birth:_____

E-mail:_____ Occupation:_____

Referral Source:

_____

Emergency Contact and phone number:

_____

Please list any medication you are taking:

_____

If you are currently under medical care, please explain:

_____

Previous experience with CranioSacral:

_____

Primary reason for appointment/ area of pain or tension:

_____

Have you ever had surgery, fractures, or recent injuries? Please give dates and explain.

_____

Are you pregnant? (Female) ___ Yes ___ No / Do you regularly exercise? ___ Yes ___ No

Please mark all conditions you have

___Allergies ___Arthritis ___HIV+/ AIDS ___Blood Pressure (high/low) ___ Insomnia

___High/Low Blood Pressure ___Bone injury ___Cancer ___Cold or Flu ___ Headache

___Diabetes ___Disc Problem ___Fibromyalgia ___Heart disease ___ Herpes

__Infection ___ Joint Injury/ Replacement ___Osteoporosis ___Neck Ache ___ Back Pain

___Shoulder Pain ___ Blood Clots ___ Varicose Veins ___ Anxiety _____Depression

___ Chronic Fatigue ___Snoring ___Sleep Apnea _____Asthma _____ADHD

___Sleep Difficulties ___Dental Bridges, Braces ___Contact lens ___ Hearing aid

Name of Health Care Provider:

I understand that the session given here is for the purpose of stress reduction, relief from muscular tension or spasm and to increase circulation and fluid flow. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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.

There is a 48-hour cancellation policy to avoid billing in full for this and future appointments, unless this document is revised.. Understanding all of this, I give my consent to receive care.

Client Signature:_____

Date:_____

Parent Signature if client is a minor_____Date: _____