chopstix LLC
acupuncture and bodywork

bodywork new patient form

206-547-1104
126 nw canal st
suite 220
seattle wa 98107

Date: ___/____/___

Name: _____ Age: _____ Date of Birth: ___/____/___

Address: _____

City, State, Zip: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

SSN#: _____ Email Address: _____ Occupation: _____

Gender: M F Height/Weight: _____

Emergency Contact: _____ Phone: ( ) _____-_____

Referred by: _____

1. Date of your last professional massage? If never, write N/A _____
2. List any stress reduction and/or exercise activities, including frequency:

_____

_____

3. List current medications, including ibuprofen, herbal remedies, etc.:

_____

_____

4. List any surgeries, injuries/accidents, major illnesses or other hospitalizations within the last 5 years or for conditions still affecting you:

_____

_____

_____

5. If you are currently under the care of a health care practitioner for any condition/injury, please provide:

Practitioner Name:_____

Phone: ( ) _____ - _____

Description: _____

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6. Insurance Information ○ private ○ group ○ automobile ○ worker's comp

Insurance Company Name: _____

Address: _____

Phone: ( ) _____ - _____

Claim/Policy/ID#: _____

7. If this visit is related to an automobile accident, please provide, if applicable:

Attorney Name:_____

Phone: ( ) _____ - _____

8. Please indicate if you now, or have in the past, had any of these conditions:

		Musculoskeletal System
Now	Past	
○	○	Bone or joint disease
○	○	Tendonitis/Bursitis
○	○	Sprains/Strains
○	○	Low Back/Hip/Leg Pain
○	○	Neck/Arm/Shoulder Pain
○	○	Spasms/Cramps
○	○	Jaw Pain/TMJ
○		Lupus
○	○	Osteoporosis
		Integumentary System
○	○	Allergies
○	○	Rashes
○	○	Athletes Foot
○	○	Herpes/Cold Sores
○	○	Other: _____

		Circulatory System
Now	Past	
○	○	Heart Condition
○	○	Varicose Veins
○	○	Blood Clots
○	○	High Blood Pressure
○	○	Low Blood Pressure
○	○	Lymphedema
○	○	Thrombosis/Embolism
○	○	Other: _____
		Nervous System
○	○	Shingles
○	○	Numbness/Tingling
○	○	Trigeminal Neuralgia
○	○	Bell's Palsy
○	○	Pinched Nerve
○	○	Other: _____

		Respiratory System
Now	Past	
○	○	Breathing difficulty
○	○	Emphysema
○	○	Asthma
○	○	Sinus Problems
○	○	Other: _____
		Digestive System
○	○	Constipation/Diarrhea
○	○	Gas/Bloating
○	○	Diverticulitis
○	○	Irritable Bowel Syndrome
○	○	Ulcers
○	○	Lymphedema
○	○	Other:_____

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	Reproductive System	**Other**

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Now	Past		Now	Past		Now	Past	
O		Pregnancy: Months: ____	O	O	Cancer/Tumors	O	O	Chronic Fatigue
O	O	Ovarian/Menstrual Problems	O	O	Kidney/Bladder Ailment	O	O	Eating Disorder
O	O	PMS	O		Diabetes: Type: ___	O	O	Migraines/Headaches
O	O	Prostrate	O	O	Drug/Alcohol/	O	O	Anxiety/High Stress
O	O	Other: _____			Caffeine/Tobacco	O	O	Depression

9. Please check all that apply today:

- O **Contact Lens** Please describe: Hard or Soft
- O **Infection** Please describe: _____
- O **Inflammation/Swelling** Please describe: _____
- O **Fever** Please describe: _____
- O **Communicable Illness** Please describe: _____

10. What areas would you like to concentrate on:

Symptom/Area	**Pain Level (0 to 10)**	**Duration of pain. How long has this bothered you?**

Name any other symptoms and/or additional remarks/comments:

_____

_____

_____

Continued on the next page.

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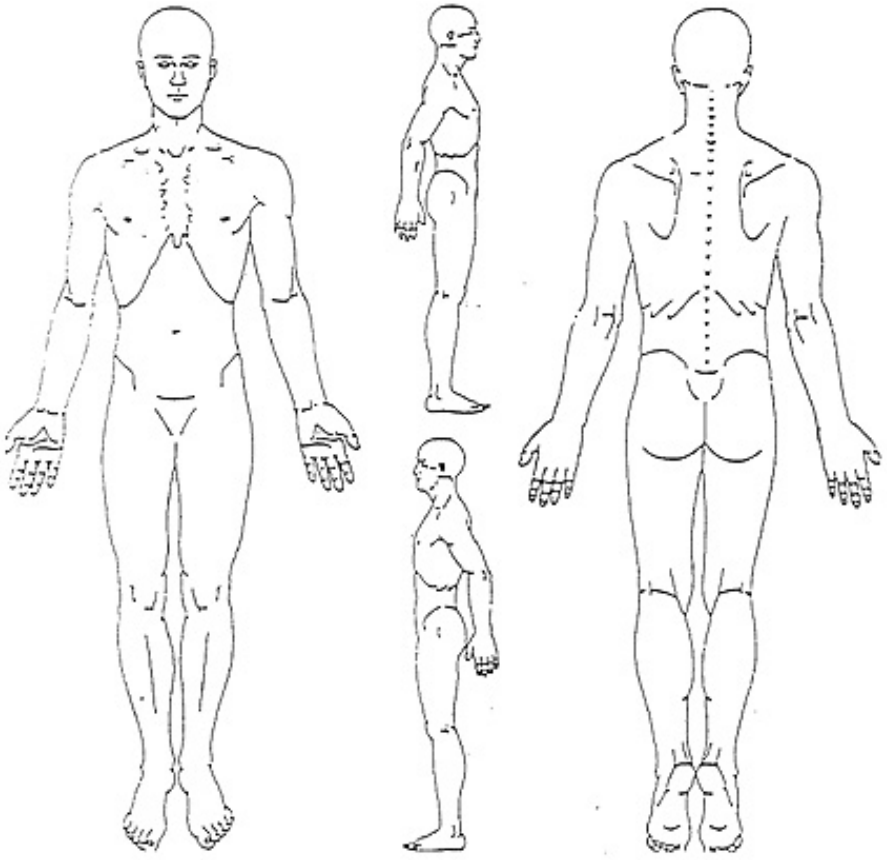
11. Circle the location of symptoms, labeling pain, stiffness/tightness, scars, swelling, spasms, etc. Also label injuries, past and present.



12. Release
Because a massage therapist must be aware of any existing physical conditions, I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any change in my health.

I understand massage therapists do not diagnose illness, disease, or any other medical, physical, or emotional disorder; nor do they perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical aliment that I have.

Unless arrangements are made beforehand, payment is due at the time of the appointment.

I agree to give 24 hours notice if I must cancel my appointment. I agree to pay a $30 cancellation fee to the massage therapist for missed appointments not cancelled within 24 hours.

Signature_____ Today's Date _____