

Seattle:
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Transitions Bodywork

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Please take a moment to complete this form, and sign it at the bottom of page 2. This will help us to know your health concerns, and enable smooth insurance billing for our office. Thank you.

Name:		Today's Date: / /	
Address:		City/Zip:	
Home Phone: - -	Cell Phone: - -	Birthdate: / /	
Email Address:		Preferred Contact: Home <input type="checkbox"/> Cell <input type="checkbox"/> Email <input type="checkbox"/>	
Gender: M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>		Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
Emergency Contact:		Emergency Phone: / /	
Physician:		Physician Phone: / /	
Occupation:		Employer:	

Health Information

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had professional bodywork? (PT, OT, massage, Feldenkrais) Which/How recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contacts, bifocals or dentures?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have <i>custom</i> orthotics (sport &/or dress)? Do you wear them?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, what week?
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly or participate in any sports? If so, what kind & how often?
<input type="checkbox"/>	<input type="checkbox"/>	Do you take any medications? If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Have you suffered an acute injury recently? If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any infectious or contagious diseases? If yes, Please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery? If yes, Please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Have you had diagnostic imaging?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have spinal problems? If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Have you been limited from your preferred sleep position?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have arthritis? If so, what type, where?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any areas that need special attention or avoidance? If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical conditions that your practitioner should be aware of before you start treatment? If yes, please describe:

* Initial session will involve a more extensive interview of your specific needs and concerns.

