Transitions Bodywork

Seattle:
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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☐ Cell☐ Email☐
Gender: M☐ F☐ Other☐		Status: Single☐ Married☐ Other☐
Emergency Contact:		Emergency Phone: / /
Physician:		Physician Phone: / /
Occupation:		Employer:

Health Information

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