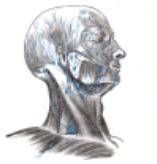
Pre/Post Surgical Intake Form



Welcome to Integrative Bodyworks LLC

Integrative Bodyworks offers Advanced Therapeutic Bodywork, Lymphatic Drainage and Visceral Manipulation techniques.

3240 Newport Street, Denver, CO 80207 Phone: 303-523-0773

Personal Information:

Client's Name _____Date ____/____/_____

Address _____ City _____ ST _____ Zip_____

Cell: _____ Age _____ Birth date ___/_____/_____ Sex: F M T O

E-Mail Address _____

_____ Initial I give my consent to contact me via email, phone, text or mail with appointment reminders.

Who can I thank for referring you? _____

E-Mail Address _____

Emergency Contact _____ Phone _____ Relationship _____

Please fill out the form as accurate as possible. All questions are important so the therapist can determine if there are any contraindications for therapeutic massage. All information is confidential. I understand that manual therapist do not diagnose disease, illness, disease or any physical to mental disorders: nor do they prescribe medical treatment, pharmaceuticals, nor do they provide spinal manipulation. I acknowledge that a Manual Lymphatic Drainage or Visceral Manipulation is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

For cancer patients:

What was your diagnosis? _____

Are you currently undergoing cancer treatment? ____ YES ____ NO Radiation ____YES ____ NO

Do you have written permission from your treatment team to receive MLD at this time? ____ YES ____ NO

What was the date of your last treatment? _____

Do you give written permission to contact your treatment team to receive MLD at this time? ___ YES ___ NO

Were drains used in the procedure? ____ YES ____ NO How many? _____

Are surgical sites healed? ____ YES ____ NO

Date of last chemotherapy session? _____

How many sessions have you had? _____ How many are recommend? _____

How many radiation sessions have you had? _____ How many are recommend? _____

Please describe the full procedure and if there were any complications. _____

_____

_____

_____

For Cosmetic Surgery patients:

Did your surgeon recommend post surgical MLD? ___ YES ___ NO

Have you been cleared by your doctor to receive MLD? ____ YES ____ NO

If so, have you received MLD after surgery? ___ YES ___ NO

How many sessions? _____

Are you in pain? ____YES ____ NO

If so, where? _____

Are you experiencing swelling or bruising? ____ YES ____ NO

If so, where? _____

Please mark ALL surgeries/procedures:

Liposuction:

____ 360
____ Abdomen
____ Waist/Flanks
____ Arms
____ Hips/buttocks
____ Back
____ Thighs
____Inner Knee
____Calves & Ankles
____ Neck/Chin

Neck & Face

____Face lift
____Rhinoplasty
____ Eyes/Brow
____ Cheek Augmentation
____Neck/Chin

Breast:

____ Augmentation
___ Implant
___Fat transfer
____Lift
____ Removal
____ Implant Revision
____ Revision
____ Nipple
___Removal
____Reconstruction

Breast Reconstruction:

____Expanders
____Areola
____Removal
____Reconstruction

Body Lifts:

____Arm Lift
____Body Lift
____ Mommy Makeover
_____Body Contouring
____ Abdominoplasty
____ BBL
____ Hip Augmentation

Gender Confirmation Surgery

Facial

____Transfeminine
____Transmasculine

Chest

____Transfeminine
____Transmasculine

Any other procedures? _____

Did you have issues with blood clots or clotting? ____ YES ____ NO

Were drains used following the procedure? ____ YES ____ NO

Were you in a compression garment? ____ YES ____ NO

Are you wearing post-surgical garments? ____ YES ____ NO

Are you noticing thickening or fibrosis? ____ YES ____ NO

Surgery Date	Hospital/Clinic	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL medications and reason for taking them.

Medication	Reason	Is this related to Surgery
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO

Prior Surgeries _____

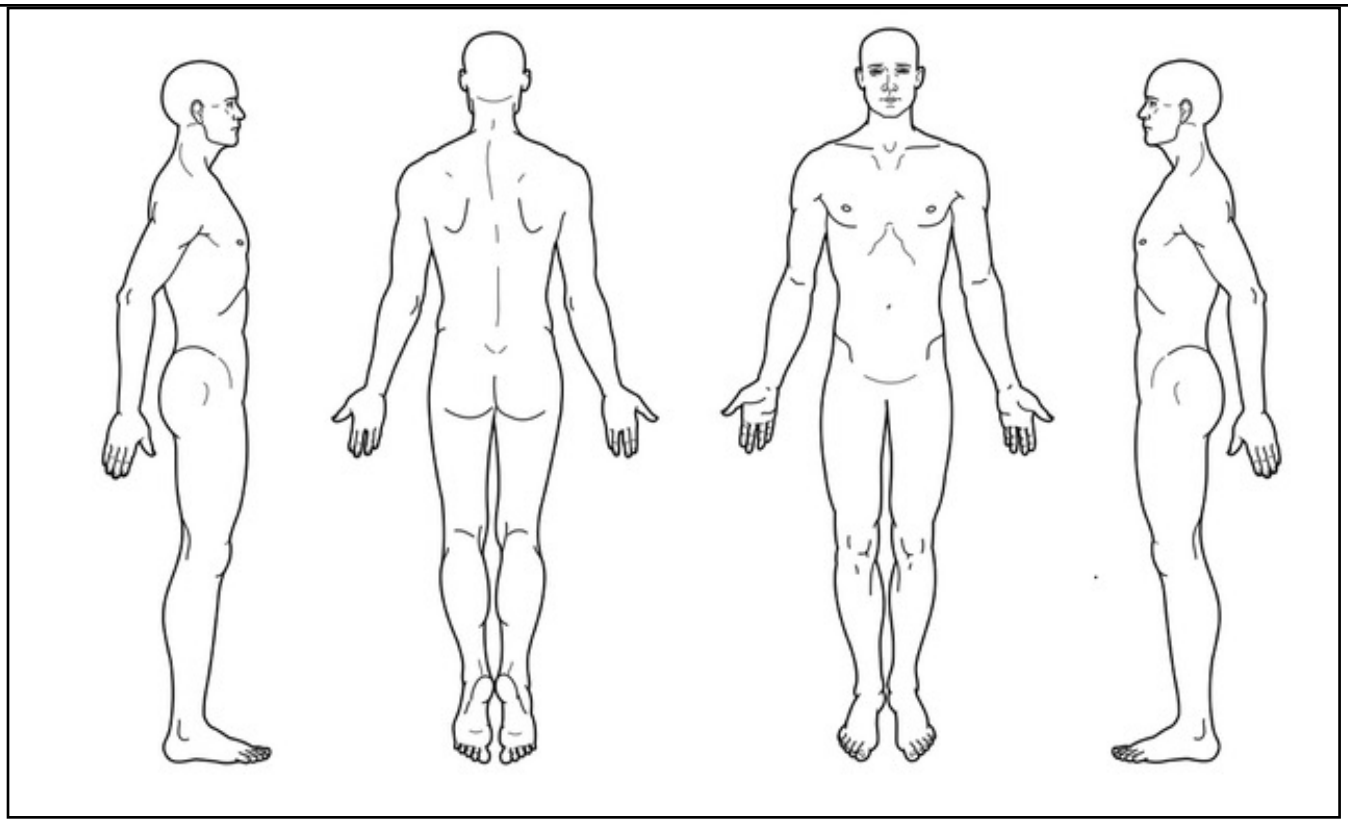
Auto Accidents _____

Falls/Injuries _____

Pregnancies _____

Are you currently pregnant? _____

Please mark all areas that apply to your surgery.



Health History

Please mark C for a current condition, P if a past condition and leave blank if not applicable.

____Abdominal Pain
____ADD/ADHD
____AIDS/HIV
____Allergies
____Aneurysm
____Ankle/Foot Pain
____Anorexia
____Anxiety
____Appendicitis
____Arm Pain
____Arthritis
____Asthma
____Auto Accident
____Autoimmune Disorder
____Back Pain
____Blood Pressure
____High
____Low
____Blood Clots
____Blood Thinner
____Broken/Fractured Bones
____Bronchitis
____Bruises easily
____Bursitis
____Cancer
____Carpal Tunnel
____Celiac Disease
____Chronic Fatigue
____Cold Sores
____COPD
____Congestive Heart Failure
____Constipation
____ Crohn's Disease
____ COVID-19
____Currently Pregnant
____Depression
____Diabetes
____Diverticulitis/ Diverticulosis
____Dizziness
____Earaches
____Ear Tubes
____Eczema
____Edema
____Emphysema
____Endometriosis
____Epilepsy
____Eye Strain/Pain
____Fainting
____Fibromyalgia
____Foot Pain
____Gas/bloating
____Gout
____Headaches
____Head Injury
____Heart Attack
____Heart Palpations
____Hepatitis
____Hernia
____Herniated Disk
____Herpes
____Hip Pain
____HIV
____Insomnia
____IBS
____IUD
____Jaw Pain
____Joint Pain
____Kidney Stones
____Knee Pain
____Leg Pain
____Low Back Pain
____Lyme Disease
____Lymph Nodes
____Enlarged
____Removed
____MASA
____Major Scars
____Mid Back Pain
____Migraine Headache
____Mold Illness
____Multiple Sclerosis
____Muscle Pain
____Nausea
____Neck Pain
____Night Sweats
____Numbness/ Tingling
____Neuropathy
____Open Wounds
____Osteoporosis/ Osteoarthritis
____Pinched Nerve
____Pneumonia
____Polio
____POTS
____Psoriasis
____Psychiatric Care
____Radiation
____Rash
____Rheumatoid Arthritis
____Sciatica
____Seizures
____Scoliosis
____Shoulder Pain
____Sinus Issues
____SIBO
____Sleep Disorders
____Spasms
____STD's
____Strains/Sprains
____Stress
____Stroke
____Surgical Implants
____Swelling of the Legs/Arms
____Tendonitis
____TOS
____Thyroid Issues
____Tinnitus
____ Tonsillitis
____Tuberculosis
____Tumors/Growths
____TMJ
____Ulcerative Colitis
____Ulcers
____Upper Back Pain
____UTI
____Varicose Veins

Is there anything else that your therapist should know before your session?

_____

_____

_____

_____

I understand that the Manual Lymphatic Drainage I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. 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 or 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.

*Please Note: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated and determine if or when, you can receive a session. After the consultation and review of the information you have provided on this form, it will be determined if MLD should be administered to you today. Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and well-being.

Integrative Bodyworks reserves the right to refuse, postpone or terminate treatment whenever they deem it in the best interest of one or more of the parties. **Initial:** _____

Release of Records/Permission to Communicate Consent: I herby give Integrative Bodyworks LLC/ Karen Urwin LMT consent to communicate with any and all practitioners involved in my treatment as she deems necessary. **Initial:** _____

Cancellation Policy: I agree to pay the full fee of the service missed if I do not give a 48 hour notice of cancellation or if I No Show an appointment. **Initial:** _____

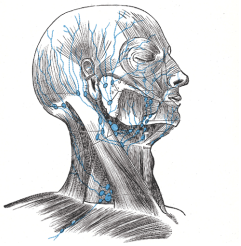
Minors: Parents must accompany any minor under 18 years of age to each and every appointment. **Initial:** _____

Client Signature: _____ **Date** _____

Practitioner Signature: _____ **Date** _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Integrative Bodyworks LLC, to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____



Integrative Bodyworks LLC

Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard your the information.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we ever sell or transfer our practice.
* We ma contact other providers with updates on your progress or concerns related to treatment.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain
circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workers' Compensation
or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves

the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:
1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals,
companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Original Effective Date: April 14, 2003

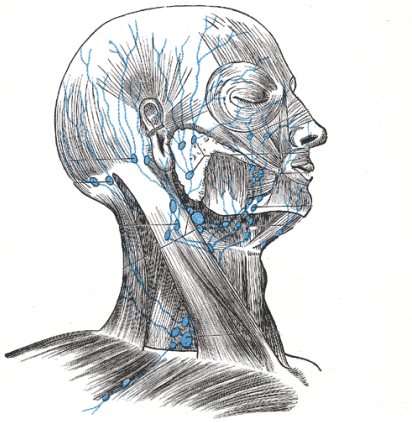
This notice remains in effect until it is replaced or amended by changes in the law.

Print Name: _____ D.O.B.: _____

Client's Signature: _____Date: _____

Parent/Guardian's Signature: _____Date: _____

3240 Newport Street Denver, CO 80207
Phone 303-523-0773 * info@ibdenver.com



Integrative Bodyworks LLC

It is always recommended that three consecutive MLD sessions are preformed. This allows the body to detox, rejuvenate while stimulating the immune system. The subtle work has profound effect on the body.

If you need to reschedule or cancel your appointment, please give at least **48 hours before the appointment to avoid the "missed appointment" fee.** You will receive a confirmation reminder via text/email 48 hours prior to your appointment. If you miss this appointment it could be weeks before another would be available, and you would be responsible for the full fee of the service. Initial _____

Here is information regarding your appointments:

Karen works from home that is located in the Park Hill neighborhood in east Denver, between Quebec and Monaco just North of Martin Luther King Blvd. The address is **3240 Newport Street, Denver, CO 80207.**

Karen accepts phone calls and text **Monday-Friday, 8:00AM-6:00PM**. If you need to contact her outside of business hours, please do so through her email at info@ibdenver.com**.**

If you arrive early to your appointment, please wait until your appointment time to ring the bell. Karen has back to back appointments and is not able to answer to door other than at times other than your scheduled appointment. If you find that you will be late, you can text her at 303-523-0773 to let her know your estimated arrival time.

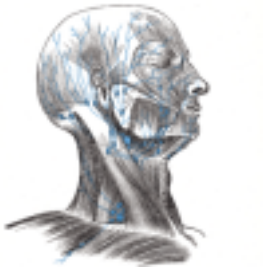
If you are not able to keep your appointment, experience has shown us that it could be weeks before another appointment would be available. For those who cancel on a regular basis you might be asked to prepay for session and at some point the prepaid sessions will no longer be refundable or services could be terminated. Karen will discuss this with you prior to this policy being instated. Initial _____

If you have active cold or flu virus, **please call at least 48 hours to reschedule.** Karen is very careful not to expose herself or the treatment room to illness which might inadvertently transmit to someone. Stay home, care for yourself, and see your primary physician if needed.

If you are recovering from the cold or flu, wait until you are **at least 90% through the illness before coming in for a session.** Your lymphatic system is already overwhelmed from the illness and to have a session with an active illness could potentially overwhelm your system even more causing you to have a relapse. If you arrive with an active cold, you will be turned away and full payment will be expected. Initial _____

If you have had an inoculation or cortisone injections, please call and discuss this with Karen before your appointment as it can be contraindicated and a certain amount of time need to pass before a session is recommended.

Karen takes and return calls between **8:00AM and 6:00PM** Monday-Friday. If you have **questions regarding your appointmen**t, please feel free to call at 303-523-0773 or via email at info@ibdenver.com.



Integrative Bodyworks LLC

Cancellation Policy

Your appointments are very important to us, they are reserved especially for you. Therefore, we respectfully request at least a **48 hour notice for cancellations or rescheduling of appointments.** This allows us time to inform clients/patients on our wait list of availability, better serving everyone. If you are not able to give the required notice you will be expected to pay the full amount of your service. Initial _____

No Shows/Last Minute Cancellations/Ongoing Cancellations
For those who No Show/Last Minute Cancellations or ongoing cancellations, you will be required to prepay for non-refundable sessions. If this continues, services will terminated.
Initial _____

Holiday Weeks
During the weeks of Christmas, New Years, Memorial/Labor Day or the 4th of July, if you have an appointment scheduled and cancel you will be expected to paid for your session in full.
Initial _____

Winter Weather
During the winter months, please pay attention to the weather forecast and make your determination regarding your appointment at least 24 hours prior to the storm. Appointments missed or cancelled on the day of the storm will be expected to be paid for in full.
Initial _____

Cold or Flu
If you arrive with a cold or the flu and it is determined that it is contraindicated for you to receive a session, you will be expected to pay for that appointment. If you have any question, phone Karen before your appointment to determine the best course of action.
Initial _____

Vaccines/Inoculations
Y**ou must wait at least 7 days before receiving any bodywork. R**eceiving bodywork before this time can possibly do one of two things: dive the vaccine deeper into your system causing reactions or it can possibly flush it out of your system, canceling it all together.
Initial _____

Questions or Concerns
If you have **concerns about your session or a reaction that you had after a session, please contact Karen at 303-523-0773 to discuss the situation prior to your next appointment.** If you arrive and it is decided that you session needs to be modified, you will be expected to pay for the full fee of the original scheduled session.

Karen can be reached at 303-523-0773 durning the business hour of 8:00AM-6:00PM Monday-Friday or via email thereafter at info@ibdenver.com.