Practitioner/Clinic Name: Sherry Hoffman

Contact Information: 847-596-1461

Health Information

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

_____

_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

_____

_____

List the medications you currently take:

_____

_____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐