BRIDGETOWN BODYWORK

Aarisa Smith, LMT #15732 ~ 8638 N Lombard St. ~ Portland, OR 97203 (760) 613 – 5022

CLIENT HEALTH INFORMATION

Date:_____

Name		Contact #s	
Address		Email	
City, State		Referred by:	
Zip		Date of Birth	

Emergency Contact	
Relationship	
Phone #	

PLEASE CHECK IF APPLICABLE (leave blank if not) AND DESCRIBE

Allergies (Skin & Other)		
Injuries		
Surgeries (type & date)		
Auto/Other Accidents (date/description/treatment)		
Heart Conditions, High/Low Blood Pressure		
Cancer (Type/Date/Treatment)		
Varicose Veins		
History of Stroke		
Epilepsy/Seizures		
Skin Conditions		
Current Pregnancy		
Arthritis		
Osteoporosis		
Asthma		
Medications (name & purpose)		
Contagious Conditions		
TMJ		
Diabetes		

PLEASE TURN OVER

What Physical Activities do you engage in? _____

_____

Other Medical Conditions or anything else you would like me to know? (Please Describe)

_____

_____

How frequently do you receive massage?_____Date of last massage?_____

Current areas of concern?_____

_____

Any treatment received or remedies attempted for this issue? _____

_____

Activities which help/make worse?_____

_____

Physician/Chiropractor/Physical Therapist Information (If Applicable)

_____

_____ I understand that the bodywork practitioner does not diagnose illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations, though occasional movements may occur in the course of normal soft tissue work.

_____ I understand that massage therapy and bodywork services offered today and in the future are not substitutes for medical examination, diagnosis, or care and it is recommended that I see a medical practitioner for any physical ailment that I may have. I understand that any information provided by the therapist does not represent a medical suggestion, is not diagnostically prescriptive in nature, and I am fully responsible for doing my own research or consulting a specialist as indicated before undertaking any actions from such information.

_____ I certify that I do not have any untreated medical conditions and that the above information is complete and accurate. I agree that it is solely my responsibility to notify the massage therapist of any changes in my health or medical condition.

_____ By signing this release, I hereby waive and release Aarisa Smith and Bridgetown Bodywork from any and all liability, past, present, and future relating to massage therapy and bodywork.

_____ I understand that the therapist may end the session for any inappropriate behavior and I will still be financially responsible for the full session, and that if insurance is filed for a session that I am financially responsible should the claim not be paid within 6 months for any reason.

_____ I understand that my information is not disclosed without my written consent (or consent of parent/guardian) unless required by law, that the below provisions constitute consent in those circumstances, and that I may revoke consent at any time. I understand I may at any time request to see the Notice of Privacy Practices, which may be revised periodically.

_____ I understand that if I cancel my session with less than 24 hours notice, that I will be responsible for the cost of the full session.

_____ I understand that if I choose to receive cupping therapy or gua sha that there may be marks associated with the treatment, and I understand that this treatment is not appropriate for individuals on blood thinners or with bleeding disorders such as hemophilia or sickle cell anemia and will update the therapist if my medication/health status changes at any time.

_____I acknowledge it is my responsibility to communicate with the therapist if anything is uncomfortable during the session as well as any changes to my health status and information (the therapist really appreciates this!!!).

_____I authorize communication to the unsecured email provided about appointment times and other treatment related information.

_____I authorize communication by text to the cell-phone number provided about appointment times and other treatment related information.

_____I authorize voice mail messages to the phone numbers provided regarding apointments and treatment related information.

_____I authorize release of my records to my other medical providers, and any attorneys or insurance companies involved in any claims for which Bridgetown Bodywork/ Aarisa Smith LMT 15732 is billing.

_____I authorize any applicable insurance company to pay directly to Aarisa Smith, LMT all benefits for sessions that may be covered, and hereby consider this an assignment of benefits to Aarisa Smith, LMT/ Bridgetown Bodywork. I further authorize Aarisa Smith, LMT/Bridgetown Bodywork to provide all information my insurance company(s) request regarding treatment. All services not covered or allowed by insurance are my full financial responsibility, and will be paid within 30 days of my notification of the insurance determination.

____I authorize written and verbal communication with my medical providers regarding my care.

____I authorize communication with the listed individual(s)or organizations _____ regarding my (circle or cross out) treatment, appointment times, billing, other subjects that may have been discussed.

____I authorize communication and sharing of records with Muscle Memory Massage

____I acknowledge that all of the above provisions, specifically including waiving liability, release of records and assignment of benefits apply equally to Muscle Memory Massage.

Signature_____Date_____

Parent/Guardian Signature if Under 18_____Phone#_____