Six Elements Bodywork, LLC

Sarah K. Carl, LMT OBMT #11624

Confidential Health History Information

CONTACT INFORMATION- PLEASE PRINT:

Today's Date: _____ Preferred Name: _____ Date Of Birth: _____

Your name as listed with government & insurance: _____

Preferred Gender Pronoun:_____ Your sex as listed with the government and/or insurance company: M F

Address, City, State, Zip: _____

Phone: _____ e-mail address: _____
Join the *infrequent* email mailing list? Y N If no, we will only use your email for office use i.e. appointment reminders.

Emergency Contact & Phone:_____ Relationship: _____

How did you find us? _____

GOALS AND CONDITION:

Goal(s) and/or chief complaint:_____

Date of onset: _____ List surgeries & injuries with approximate dates: _____

_____

Current medications/herbs:_____

Other providers you are seeing (Check all that apply):
_____Medical Doctor _____Naturopathic _____Chiropractor _____Acupuncture _____Physical Therapy _____Other

HEALTH HISTORY- Check all that apply

___ Tendency toward blood clots
___ Circulatory or heart condition
___ Heavy or unusual menstrual flow
___ Skin Condition (rash, warts, fungus, athlete's foot, other)
___ Lymphatic condition (swollen glands, lymphoma, other)
___ Lymph nodes removed
___ Foreign bodies (Mesh, IUD, Pins, bolts, artificial joints, etc)
___ Tendency for dislocations
___ Recent injections (cortisone, Botox)
___ Aneurysm
___ Kidney Disorder
___ Neurological condition (sciatica, stroke, epilepsy, other)
___ Bone Conditions (fracture, cancer, osteoporosis, other)

Current	Past	
Musculo-Skeletal		
____	____	tendonitis
____	____	bursitis
____	____	arthritis
____	____	scoliosis
____	____	osteoporosis
____	____	sprains/strains
____	____	frequent headache
____	____	head injury
____	____	disc problems
____	____	hernia
____	____	jaw pain/TMJ
____	____	whiplash
____	____	fibromyalgia
Circulatory		
____	____	varicose veins
____	____	diabetes: I II
____	____	stroke
____	____	H/L blood pressure
____	____	pacemaker
Digestive		
____	____	Constipation
____	____	IBS
Respiratory		
____	____	asthma
____	____	bronchitis
____	____	emphysema
____	____	pneumonia
____	____	labored breath
____	____	other_____
Psychological		
____	____	eating disorders
____	____	anxiety
____	____	depression
____	____	chemical dependent
____	____	other_____
Other		
____	____	chronic pain
____	____	fatigue
____	____	sleep disorders
____	____	immune deficiency
____	____	**Serious Illness**
____	____	**Any Other Issue**

_____

—Please Turn Over—

Six Elements Bodywork, LLC

Sarah K. Carl, LMT OBMT #11624

Systemic Health Information

Bowels: How often do your bowels move? _____ ☐ Diarrhea ☐ Constipation ☐ Other? _____

Does your waste include ☐ undigested food ☐ blood Comments: _____

Sleep: Average amount per night? _____ Trouble falling/staying asleep or waking early? _____

During the night: ☐ Nightmares ☐ Interrupted sleep ☐ agitated sleep ☐ other? _____

Feel rested in morning? _____ Energy throughout day? _____

Quality of life: joy at work, home, other _____

Any tumors or serious diseases? _____

Have you had lymph nodes removed? _____

Do you have: ____uterus ___ovaries Are you pregnant?_____ Due Date: _____; Any: Fibroids - Endometriosis - Other ?

Have you had any difficult pregnancies? _____

Have you ever had intense menstrual symptoms?_____

Any breast tenderness, masses? _____ Any menopausal intensity? _____

Additional Comments: _____

_____

_____

Office and Financial Policies

- **Cancellation Policy**: 24 hour notice is required. Your therapist reserves the right to bill you for late notice or no-shows. Insurance does not cover this cost so you will be billed directly.
- All out of pocket payments including copays and coinsurance are due at the time of service.

Statement and Release – Please Read Carefully

- Bodywork requires close contact of receiver and provider. I am in control of my own body at all times. I will communicate any discomfort to my provider immediately so s/he may change or end the session. If my therapist feels uncomfortable, s/he may communicate this to me and/or end the session with full payment expected.
- Massage sessions are not intended to diagnose or cure medical, emotional or mental conditions and should not replace consultation or treatment with a qualified physician or mental health therapist.
- I agree *not* to hold liable Six Elements Bodywork, LLC, Sarah K. Carl, or authorized provider working under permission of SEB for any adverse affects or reactions including but not limited to: dizziness, soreness, bruising, allergic reaction or potential burns. It is my responsibility to inform my therapist of any negative effects so that s/he can alter or end the session. I also do not hold my provider liable for adverse effects I failed to notice or communicate.
- I have been given the chance to read the Privacy Policies Notice. I understand how my private health information may be used.
- All information I have provided on this form is true and accurate to the best of my knowledge. I agree to provide written updates of my address, health or other information needed to conduct treatment safely and effectively and obtain payment.
- By signing below, I declare that I understand and agree to all statements listed above.

___/___/____ _____ _____

Date **Print Legal Name of Patient** **Signature of patient or guardian if patient is a minor**

Office Use: