Bo Vi Massage

GENERAL INFORMATION

Name: _____ Date: _____

Home PH:_____ Cell PH: _____

Email Address: _____

Birth Date: _____ Age: _____ Sex: **[M]** **[F]**

Address: _____City: _____State:____ Zip: _____

Occupation: _____ Employer: _____ **Full-time** or **Part-time**

Circle one: [**single**] [**married**] [**widowed**] [**divorced**] [**separated**] Spouses name: _____ Occupation: _____

Where did you hear about our massage service? _____

HEALTH HISTORY

What would you like to achieve from your massage session today: _____

Any current injuries or painful areas we should know about: _____

Do you have any known allergies to lotions or oils? _____ Do you want aromatherapy? [Y] [N]

Aromatherapy scents (please circle one): [**Orange Spice**] [**Caribbean Coconut**] [**Cinnamon**] [**Peppermint**] [**Lavender**] [**Lemon**]

Have you ever sought services or had complaints for any of the following?

__Headaches	__Carpal Tunnel	__Asthma	__Digestive Problems
__Neck Pain	__Vertigo	__Allergies	__Pain Between Shoulders
__Mid-Back Pain	__Low- Back Pain	__Loss of Balance	__Tension Across Top of Shoulder
__Sciatic Pain	__Dizziness	__Menstrual Pain	__Numbness in Arms/Legs
__Leg/Hip Pain	__Fatigue	__Arm Pain	__Other: _____

If you could get rid of one of these concerns, which would you choose? _____

How long have you had the concern? _____ When is it at its worst, how does it feel? _____

Have you been adjusted by a chiropractor before? [YES] [NO] is yes, date of last adjustment: _____

Have you ever sought services for this or any other health concern from the following?

__Massage Therapist __Acupuncturist __Naturopath __Yoga __Physical Therapist

__Personal Trainer __Nutritionist __Rolfer __Pilates __Other: _____

When was your last massage? _____ Are you pregnant [**Y**] [**N**] # Weeks: _____

Which styles of bodywork do you prefer: _____ How Often: _____

****PLEASE FILL OUT THE BACK OF THIS PAGE****

INFORMED CONSENT OF CARE

In undertaking a massage at Bodywork By Vitality, I (print name)_____Agree that: The purpose of the massage is to provide stress relief, pain control and relax. The therapist will not treat, prescribe or diagnose an illness, disease or any other physical or mental disorder. Nothing said in the course of a massage session should be misconstrued to be such. I understand that a massage involves having my body touched. I hereby authorize the therapist to perform massage. I understand that any relief of physical or emotional symptoms is the product of processes, which reside within me. The power to heal comes from within. I understand that I am responsible for my emotions, feelings, body and belongings and the therapist is responsible only for giving a massage. Control of the session is always mine and I can stop it at any time. In the spirit of this understanding, I agree to hold Bodywork by Vitality and its employees blameless from any problem which may arise as a result of my massage.

***Signed*_____*Date*_____**

HIPPA NOTICE OF PRIVACY PRACTICES

Body Work by Vitality and Vitality Chiropractic:

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Vitality at 303-346-7095. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. As required by the privacy regulations, I am aware that Body Work by Vitality has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

By my signature below I acknowledge receipt of the Notice of Privacy Practices, I provide Vitality and Body Work By Vitality, with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____

Signature of patient or authorized representative **Date**

_____

Printed name if signed on behalf of patient (i.e. Parent, legal guardian, personal representative, etc.)