Santa Cruz Naturopathic Medical Center

Date: _____

Bodywork Client Information

Name_____ Occupation_____

Address_____ Referred By_____

City_____ State_____ Zip_____ Emergency Contact:

Phone (H)_____Phone (C)_____ Name_____

Birth Date_____ Relation_____

Email_____ Phone #_____

☐ we'd like to keep you up to date on specials and events at our Center. Check this box to be added to our email list?

- Are you currently under the care of a health practitioner? Yes ☐ No ☐ If Yes what are you being seen for?

_____

- Do you perform any repetitive movement in your work, sports or hobbies? Yes ☐ No ☐ If Yes please describe:

_____

- Please list any significant injuries, surgeries, major illnesses or accidents (include the year)

_____

- Please list any medications you are currently taking. Include over the counter, supplements and prescribed:

_____

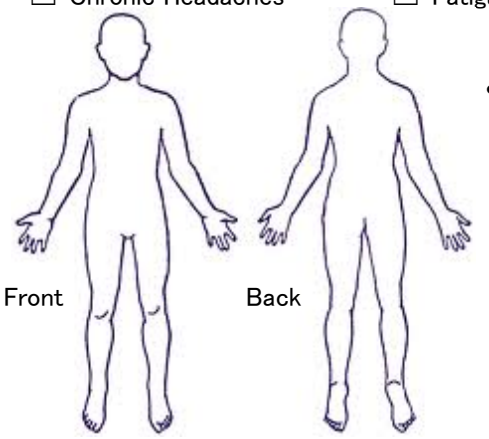
- How can we best support you today? What are your goals for today's session?

_____

- Are you ? ☐ Right or ☐ Left Handed • What is your current level of stress ? 0 1 2 3 4 5 (circle one)

Please mark the boxes as they pertain to you. P = Past, C = Current

☐ Arthritis	☐ Constipation/Diarrhea	☐ Fibromyalgia	☐ Do you experience PMS
☐ Asthma	☐ Depression/Anxiety	☐ Heart Condition	☐ Are you Menopausal
☐ Bladder/Kidney Problems	☐ Diabetes	☐ High/Low Blood Pressure	☐ Sinus Trouble
☐ Blood Clots	☐ Dizziness/Fainting	☐ Insomnia/Problems Sleeping	☐ Skin Conditions
☐ Cancer	☐ Epilepsy/Seizures	☐ Jaw Pain	☐ Spinal Problems
☐ Chronic Headaches	☐ Fatigue	☐ Osteoporosis	☐ Are You Pregnant ☐ How many months



- Are there particular areas of your body where you are experiencing tension, stiffness, pain or discomfort? Please mark on the body where.

_____

• Bodywork is done to assist with well being and the healing process. Therapists are trained in their specific fields and are not giving medical advice. All information shared will be kept confidential.

Signature_____ Date_____