Soulstice
Innovators of Peri-operative Therapy

Confidential Client Information and Health History

Today's Date: _____ Date of Birth: _____ Gender: M F

Full Name: _____ Nickname: _____

Address: _____
Street Apt # City/State Zip Code

Phone - Home _____ Cell _____Work/Other _____

E-mail address: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? Physician Friend Relative Health Fair Website Gift Certificate Other
Please include the specific name of referring individual so that we may thank them:

What physical activities/exercise programs are you involved in? How often? What kind? _____
_____

Are you a recent surgical patient? **YES NO** *(If yes, please complete the following)*

What was the **date** of your surgery? _____

What **procedure**(s) did you undergo? _____

Who was your **surgeon**? _____Are you wearing a **compression garment**?_____

Please tell us why you're here to see us _____
Other pertinent medical history (i.e. medical conditions, past surgeries, injuries, accidents, chronic pain):

_____

Are you currently taking any medications? (including herbs, vitamins and over-the-counter meds)? **YES NO**
If yes, please describe (temporary or regular) _____
_____

What is your main work activity? **PHONE SITTING COMPUTER DRIVING MANUAL OTHER**

Have you ever had massage? **YES NO** For what reason? _____
How long ago? _____ How was your experience? _____
Are you currently receiving any other treatment modalities *(i.e. acupuncture, physical therapy, chiropractic, naturopathic, etc.)*?_____

Do you have any known allergies?_____

Please check any and all that apply to your present health condition

____Low Back Pain
____Mid Back Pain
____Upper Back Pain
____Neck Stiffness
____Chest Pain
____Headaches
____TMJ/Jaw Pain/Grinding
____Vision Problems
____Contact Lenses
____Digestive Problems
____Sciatica
____Numbness/Tingling
____Shooting Pains
____Varicose Veins
____Osteoporosis
____Scoliosis
____Rheumatoid Arthritis
____Osteoarthritis
____Skin Condition/Rash
____Pregnant
____Bruise Easily
____Area of Inflammation
____Bursitis
____Heart Condition
____Low Blood Pressure
____High Blood Pressure
____Swollen Ankles
____Depression
____Feelings of Anxiety
____High Stress
____Sleep Problems
____Sinus Problems
____Chronic Pain
____Muscle/Joint Pain
____Sprains/Strains
____Tendonitis
____Blood clots
____Diabetes
____Cancer/Tumors
____Infectious Disease
____Smoker

- I hereby authorize the release of my medical information necessary to provide effective care and communication between Soulstice and my referring physician, healthcare providers, and/or insurance companies to process my insurance claim *(if applicable).* This may include intake forms, chart notes, correspondence, billing statements, any other information either written or verbal.
- I am responsible for all charges for services rendered. If my insurance company denies benefits or makes partial payments, if applicable, I am responsible for any balance due.
- I understand the benefits and risks of this service and give my consent to receive this service. I will consult my Soulstice therapist with any questions or concerns immediately. I have discussed/stated all medical conditions that I am aware of and will keep my provider informed of any changes.
- Your therapist cannot make any diagnosis. Any suggestions made during your visit are recommendations or observations. You will be referred to your surgeon/medical provider for any specific questions regarding your health and/or surgery.
- Scheduling & Cancellation Policies: Soulstice enforces a 24-hour cancellation policy. Failure to cancel within 24 hours or failure to appear for a scheduled appointment will be subject to forfeiture and/or will be charged accordingly. I understand that insurance companies do not pay for cancellation fees.
- Insufficient funds: Client will be charged a $20 fee in addition to the full payment for services rendered for any returned checks.

I have read and I understand the above policies.

Client Signature: _____ Print Name: _____ Date: _____

Consent for Minors: By my signature below, I hereby authorize massage therapy treatment to my child or dependent as deemed necessary.

Signature of Parent or Guardian: _____ Date: _____

Reviewed by Therapist: _____ Copy of policies given to patient: Y N Date: _____

For office use: Information entered into client database on _____ by _____

Soulstice, Ltd. 3470 S. Sherman Ste. 3 Englewood, CO 80113 **303-628-0205**
SoulsticeWellness.com