Soulstice, Ltd.
Innovators of Peri-Operative Therapy

Confidential Client Information and Health History

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

Full Name: _____ Nickname: _____

Address: _____
Street Apt # City/State Zip

Primary Phone: _____ *Cell Home Work* Other Phone: _____

Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Contact Phone: _____

How did you hear about us? *Surgeon Physician Friend/Family Website Gift Certificate Other*

Please include the name of the referring individual: _____

Please tell us why you're here to see us: _____

If you are a recent surgical patient, please complete the following:

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

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

Please list any medications and/or supplements you are currently taking, including herbs and vitamins:

_____

_____

What is your main work activity? *Phone Computer Desk Driving Manual Other:* _____

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

_____

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 provide **ALL** pertinent medical history, including past surgeries, medical conditions, concussions, injuries, and accidents: _____

_____

_____

3470 South Sherman Street, Suite 3, Englewood, CO 80113
(303) 628-0205 SoulsticeWellness.com

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*Please check any and all that apply to your **past and 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
__ Shingles
__ Eczema
__ Bruise Easily
__ Chronic Pain
__ Area of Inflammation
__ Bursitis
__ Heart Condition
__ Low Blood Pressure
__ High Blood Pressure
__ Swollen Ankles
__ Pregnant
__ Anxiety
__ Depression
__ High Stress
__ Sleep Problems
__ Sinus Problems
__ Concussion/TBI
__ Muscle/Joint Pain
__ Sprains/Strains
__ Tendonitis
__ Blood Clots
__ Diabetes
__ Cancer/Tumors
__ Infectious Disease
__ Smoker
__ Other

Provide any additional information here: _____

_____

Please read through the following policies, then sign and date below.

- 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, and any other information either written or verbal.
- **I am responsible for all charges for services rendered at time of service**. 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 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/Guardian: _____ Print Name: _____ Date: _____

For Office Use:
Reviewed by Therapist: _____ Copy of policies given to patient: *Yes* *No* Date: _____
Information entered into client database on _____ by _____

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