

## DEMOGRAPHIC INFORMATION

First Name:	Last Name:	MI:
Street Address:		Apt #:
City:	State:	Zip:
Cell #:	Texts?: Y/N	Home /Work ? #:
Email:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Birthdate:	Job/Daily Tasks?	
How did you hear about us?		Are you on Facebook? Y or N

Date:

Last Name:

## EMERGENCY CONTACTS

Emergency Contact:	Relationship:
Address:	Phone #:

I understand that the services offered through *The Body Works! LLC* and companies or services associated with them are not a substitute for medical care and that any information provided is for educational purposes only and is not diagnostically prescriptive in nature. I agree to actively participate, as much as possible, in my own healing. I have disclosed all known medical and physical conditions and will provide updates. I understand all policies (cancellation, timeliness) and will adhere to them. I recognize potential risk to the musculoskeletal system (dizziness, discomfort in breathing, heart attack) and hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in services offered. No services at *The BodyWorks! LLC* are sexual and any said remarks or actions will end the service. By signing this consent form, I understand that I am personally responsible for my actions during my tenure with the *The Body Works! LLC* and that I waive the responsibility *The Body Works! LLC* if I should incur any injury as a result of my negligence.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

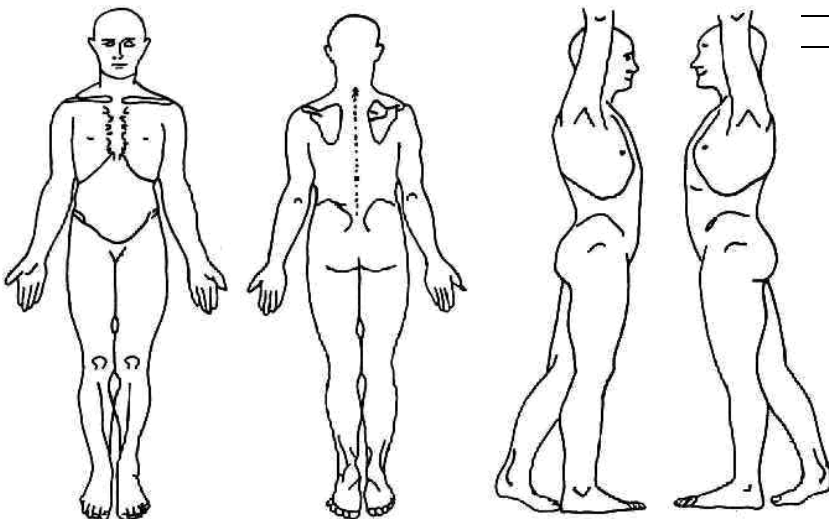
First Name:

## MEDICAL HISTORY

Current Physician(s): \_\_\_\_\_

Indicate areas of discomfort below.

What activities/movements cause discomfort?



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check YES or NO. Please explain any Yes answers!**

Y \_\_\_\_\_ N \_\_\_\_\_ Any contagious disease

Y \_\_\_\_\_ N \_\_\_\_\_ Any recent surgeries

Y \_\_\_\_\_ N \_\_\_\_\_ Any recent injuries

Y \_\_\_\_\_ N \_\_\_\_\_ Arthritis

Y \_\_\_\_\_ N \_\_\_\_\_ Cancer

Y \_\_\_\_\_ N \_\_\_\_\_ Diabetes

Y \_\_\_\_\_ N \_\_\_\_\_ Headaches

Y \_\_\_\_\_ N \_\_\_\_\_ Heart Problems

Y \_\_\_\_\_ N \_\_\_\_\_ Hematoma, Bruise

Y \_\_\_\_\_ N \_\_\_\_\_ High Blood Pressure

Y \_\_\_\_\_ N \_\_\_\_\_ Lymphedema, Swelling

Y \_\_\_\_\_ N \_\_\_\_\_ Pregnancy. High Risk? Y/N

Y \_\_\_\_\_ N \_\_\_\_\_ Other Medical Condition