WindyWoods

Medical Integrative Bodywork and Massage

Lynne Schopf, AAS, LMT, COMT

Client name: _____ Date: _____

Address: _____

Dob: _____ Status: Married Single

Email: _____

Phone: H/C_____

Occupation/student status: _____Employer/school_____

Hobbies/sports: _____

Date of injury: _____How was injury sustained? _____

Referring Health Care Provider: _____Cleared for massage? Y N

No Fault Insurance Provider: _____

Address: _____

Ins contact person: _____ Phone & ext:_____

Claim # _____

Is there is any chance that you may be pregnant: Y N

Please review the following list. Check or explain anything that might be relevant.
Please indicate: **(P)** past conditions, **(C)** current conditions **(M)** medications (specify next to the condition)

_____Abdominal pain
_____Allergies
_____Arthritis
_____Auto-immune
_____Back pain
_____Bowel dysfunctions
_____Broken bones
_____Cancer
_____Cardiac/circulatory
_____Chronic pain
_____Carpal tunnel syndrome
_____Surgeries
_____Decreased range of motion
_____Depression
_____Diabetes
_____Fibromyalgia
_____Headaches
_____High blood pressure
_____Injury
_____Muscle strain/sprain
_____Numbness/tingling
_____Osteoporosis
_____Scoliosis
_____Skin cuts/bruises/rash
_____Stomach disorders
_____TM disorder
_____Varicose veins
_____Whiplash disorders

_____Other_____

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Client name: _____Cl#_____Date: _____

Date **symptoms began:**

Please explain what you were doing at the time of your injury or **how this injury occurred** (for ex: auto accident, repetitive motions at work, walking, bending, etc):

Please list any other **modalities** you are ***currently*** using to treat this injury or condition and practitioners name(ex: PT, acupuncture, etc.):

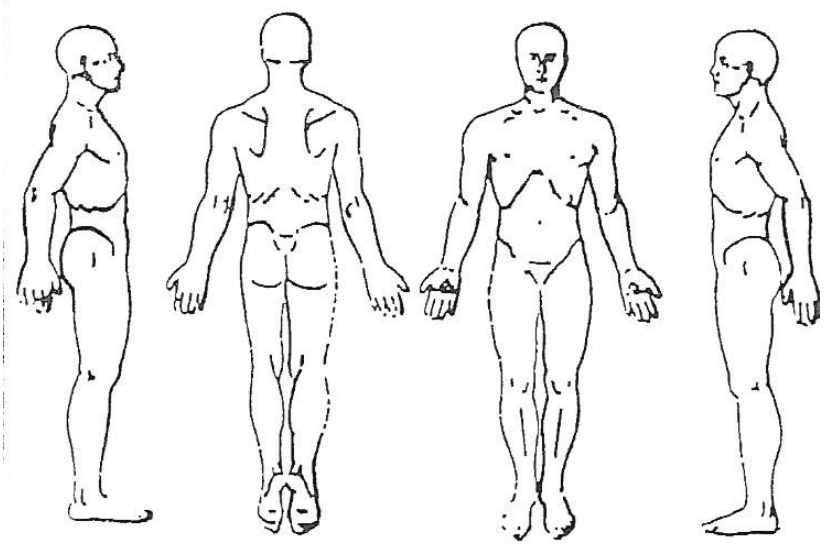
Are these treatments helping you?:

Past treatments for same condition:

How was your **past** treatments helpful**?:**

Please list activities are you having difficulty doing:

Please shade in the areas that are painful:



Please **circle** pain level **today** (minor) 1 2 3 4 5 6 7 8 9 10(severe)

Pain description (circle): Parenthesis sharp burning dull aching other (describe)

WindyWoods Medical integrative Body Therapies and Massage

Client name: _____Cl#_____Date: _____

What are your **short-term goals** for orthopedic treatment?

What are your **long-term** goals?

Previous massage/bodywork experience: _____

Medical Integrative Bodywork is assessment/outcome based, and can be focused treatment specific to your current condition. However, conditions do not exist apart from the rest of the body so structural assessment (posture) will also be evaluated.

For women: A bathing suit (2 piece) or loose shorts and sports bra/tank top; **for men**: bathing suit or loose fitting shorts can be worn for treatments.

Session duration will vary depending on the treatment plan for the session with the initial taking longer for intake and assessment.

You have the right to stop your session at any point!

All information disclosed (written, verbal) is strictly confidential.

Payment will be the responsibility of the client at the time of treatment and a receipt will be provided to turn into your insurance co.

I have reviewed this intake with Lynne Schopf and to the best of my knowledge, all information given is correct and I understand the massage procedure and payment schedule.

HIPPA release: I authorize the release of my complete health record relating to Intake, assessment and treatment by Lynne Schopf, LMT to my other health care providers

Client signature: _____Date_____