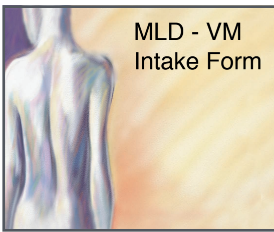

Welcome to Integrative Bodyworks LLC

Integrative Bodyworks offers Advanced Therapeutic Massage, Lymphatic Drainage and Visceral Manipulation techniques.

3240 Newport Street, Denver, CO 80207 Phone: 303-523-0773

Please fill out the form as accurate as possible. All questions are important so the therapist can determine if there are any contraindications for therapeutic massage. All information is confidential. I understand that massage practitioners do not diagnose disease, illness, disease or any physical to mental disorders: nor do they prescribe medical treatment, pharmaceuticals, nor do they provide spinal manipulation. I acknowledge that a massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

Client's Name ____Date ____/____/______________

Address _________________________________ City _______________ ST ______ Zip___________

Cell: ____________________ Work: ____________________ Home: __________________________

Age _______ Birth date ___/_____/_________ Sex: F M Occupation: __________________

How did you hear about us? ____

E-Mail Address ____

Emergency Contact ____________________ Phone __________________ Relationship ___________

Reason for Visits ____

What do you want to accomplish from this session?____

When did symptoms appear? ____

Describe symptoms/pain. ____

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain). _____________________

Does it interfere with: Work ____ Sleep ____ Daily Routine ____ Recreation _____

Activities or movements that are painful to perform: Sitting ____ Standing ____ Walking ____

Bending ____ Lying Down ____ Lifting _____

What treatments have you already received for your condition? Medications ____ Surgery ____

Chiropractic ____ Physical Therapy ____ Medical Doctor ____ Neurologist ____

Massage Therapy ____ Other _______

Name and Phone # of Referring Doctor: ____

Health History

____ADD/ADHD	____Cold Sores	____Hernia	____Sciatica
____AIDS/HIV	____Congestive Heart Failure	____Herniated Disk	____Scoliosis
____Allergies	____Constipation	____Herpes	____Seizures
____Aneurysm	____Crohn's Disease	____Hip Pain	____Shoulder Pain
____Ankle/Foot Pain	____Depression	____IBS	____Sinus Congestion
____Anorexia	____Diabetes	____Kidney Stones	____Spasms
____Anxiety	____Dizziness	____Knee Pain	____STD's
____Appendicitis	____Earaches	____Leg Pain	____Strains/Sprains
____Arm Pain	____Ear Tubes	____Low Back Pain	____Stroke
____Arthritis	____Eczema	____Lyme Disease	____Tendonitis
____Asthma	____Edema	____Mid Back Pain	____TOS
____Auto Accident	____Emphysema	____Migraine Headache	____Thyroid Problems
____Back Pain	____Endometriosis	____Multiple Sclerosis	____Tinnitus
____Blood Clots	____Epilepsy	____Nausea	____ Tonsillitis
____Blood Thinner	____Eye Strain/Pain	____Neck Pain	____Tuberculosis
____Broken Bones/ Fractured Bones	____Fainting	____Numbness/Tingling	____Tumors/Growths
____Bronchitis	____Fibromyalgia	____Open Wounds	____TMJ
____Bruises easily	____Gas/bloating	____Osteoporosis	____Ulcerative Colitis
____Bursitis	____Gout	____Pinched Nerve	____Ulcers
____Cancer	____Headaches	____Pneumonia	____Upper Back Pain
____Carpal Tunnel	____Head Injury	____Polio	____Varicose Veins
____Celiac Disease	____Heart Attack	____Psoriasis	
____Chronic Fatigue	____Hepatitis	____Psychiatric Cond.	
		____Radiation Site	

Descriptions & Dates on the following:

Recent Accidents ____

Lymphatic System Conditions ____

Immune System Conditions ____

Hospitalization/Surgeries you have had ____

Recent Infections ____

Falls/Injuries ____

Pregnancies ____

Medications ____

Cancellation Policy: I agree to give a 24 hour notice of cancellation or will be charged half of the amount of service allotted and the full amount if I no show an appointment. **Initials:** ___________

Patient Signature: ____________________________ Date: _____/_____/_________

Parent/Guardian Signature: ____________________________ Date: _____/_____/_________