FOCUS
BODYWORK

CLIENT INFORMATION FORM

First Name: _____ Preferred Pronouns: _____

Last Name: _____ Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____ Email:_____

Occupation: _____ Referred By: _____

Activities/Hobbies: _____

Health History: ❍ Present (within a year) ❑ Past

CARDIOVASCULAR

❍ ❑ High blood pressure
❍ ❑ Low blood pressure
❍ ❑ Heart attack
❍ ❑ Heart disease
❍ ❑ Phlebitis/varicose veins
❍ ❑ Hemophilia
❍ ❑ Stroke
❍ ❑ Thrombosis
❍ ❑ Pacemaker
❍ ❑ Congestive heart failure

HEAD NECK

❍ ❑ Headaches
❍ ❑ Migraines
❍ ❑ Ringing in ears
❍ ❑ Vertigo/dizziness
❍ ❑ Hearing loss
❍ ❑ Jaw pain (TMD)
❍ ❑ Vision problems

AUTO-IMMUNE

❍ ❑ Fibromyalgia
❍ ❑ ME/CFS
❍ ❑ HIV/AIDS
❍ ❑ Rheumatoid Arthritis
❍ ❑ Other: _____

RESPIRATORY

❍ ❑ Asthma
❍ ❑ Sinusitis
❍ ❑ Chronic cough
❍ ❑ Emphysema
❍ ❑ Tuberculosis

NERVOUS SYSTEM

❍ ❑ Sensory loss/change
❍ ❑ Sciatica
❍ ❑ Seizures
❍ ❑ Numbness/tingling:
_____
❍ ❑ Epilepsy
❍ ❑ Multiple sclerosis
❍ ❑ Bells Palsy
❍ ❑ Trigeminal Neuralgia

MUSCULOSKELETAL SYSTEM

❍ ❑ Osteoarthritis: _____
_____
❍ ❑ Bursitis: _____
❍ ❑ Tendonitis: _____
❍ ❑ Artificial joint: _____
❍ ❑ Pins/plates: _____
_____

SKIN & INFECTIONS

❍ ❑ Hepatitis
❍ ❑ Herpes
❍ ❑ Lyme disease
❍ ❑ Psoriasis
❍ ❑ Eczema
❍ ❑ Infectious skin conditions

MENTAL HEALTH

❍ ❑ Depression
❍ ❑ Bi-polar Disorder
❍ ❑ ADHD
❍ ❑ Anxiety
❍ ❑ Other: _____

OTHER CONDITIONS

❍ ❑ Diabetes
❍ ❑ Cancer
❍ ❑ Thyroid
❍ ❑ Digestive conditions
❍ ❑ Long COVID
❍ ❑ Fatigue
❍ ❑ Other: _____
_____
❍ ❑ Miscarriage
❍ ❑ Pregnant

Any significant injuries or accidents? Approximate date? _____

_____

Any surgeries or hospitalizations? Approximate date? _____

_____

Any current prescriptions or over-the counter medications?_____

What is your current exercise/activity routine?_____

Are you currently receiving care from other health professionals?

❍ Physical/Movement Therapist ❍ Pyschotherapist ❍ Medical specialist(s): _____

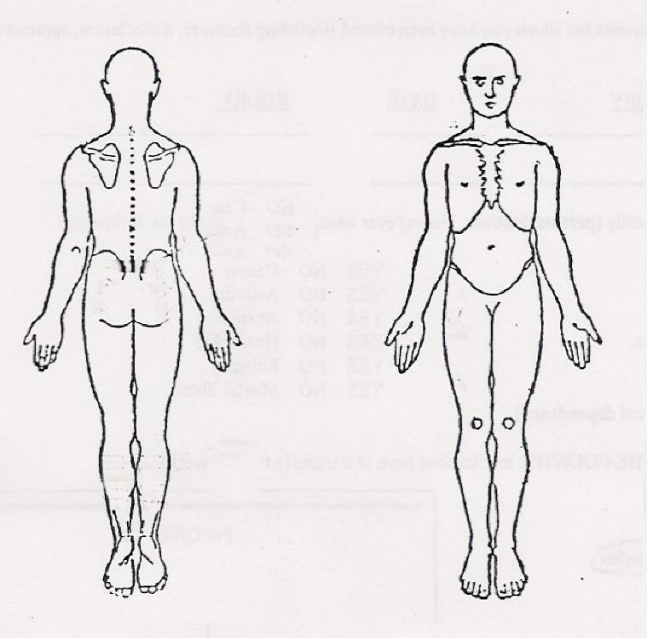
❍ Acupuncturist ❍ Chiropractor _____

What prompted you to seek treatment with us? _____

Have you had therapeutic massage before? YES NO

Are you currently experiencing or recently experienced pain/discomfort? _____

If yes, please tell us more:



What is the range of pain?

0- - 1 - - 2 - - 3 - - 4 - - 5 - - 6 - - 7 - - 8 - - 9 - -10

none unbearable

Describe the kind of pain _____

_____

When do you experience it? _____

_____

When did the pain begin? _____

_____

Is it getting better or worse? _____

What activities alleviate the pain? _____

_____

What activities aggravate the pain? _____

_____

What are your goals and expectations from this treatment? _____

THERAPIST INTAKE NOTES:

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DISCLAIMER/

ACKNOWLEDGEMENT OF RESPONSIBILITIES

I understand that massage therapy given here is for the purpose of relief of soft tissue restriction, low grade (3) joint mobilization and/or nervous system regulation. It may impact circulation and fluid flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment of pharmaceuticals, nor does the therapist perform any spinal manipulations. It has been made clear to me that this massage therapy is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Per the Utah Massage Therapy Practice Act (58-47b-501), I consent to massage of and around the breast tissue for the purpose of releasing adhesions and trigger points in the muscle, connective tissue, and scar tissue of the upper torso and/or to increase and improve the flow of lymphatic fluid. When necessary to access affected tissue, if the client consents, the breast tissue may be exposed while that area is being treated. I understand that I can alter, or withdraw, my consent for this treatment and/or treatment plan at any time.

I understand that any movement therapy activities including The **GYROTONIC EXPANSION METHOD™** undertaken here are for the purpose of relief of soft tissue restriction, improve range of motion, increase strength and improve coordination. In any physical activity, risk of serious physical injury is possible. Movement therapy is no substitute for medical diagnosis and/or treatment. I have no medical condition, which I am aware of, that would prevent me from taking part in classes or workshops, and I assume responsibility for any risk or injury I may sustain as a result of my participation. I assume the responsibility of moving at my own pace and ability and assume any risk of Gyrotonic movement or other activity and release the provider from any liability claims. I have read this release and waiver of liability and understand its contents. I agree to the terms and conditions stated above.

Cancellation Policy

In order to allow clients at Focus Bodywork to receive the services we provide, we request a 24-hour notice of cancellation prior to the time of your appointment. If proper notice is not given, you will be billed the full amount of your visit.

Signature_____ Date_____

[Signature of Guardian, if client is a minor.]