Adult Health History: 13 years and older

Oceana Bodyworks

General Information: _____ Today's Date: _____

Name: _____ DOB: _____

Address: _____ City, Zip: _____

Phones: Primary:_____ Other: _____

Email:_____ Referred by: _____

Emergency contact name and phone:_____

Doctor's name and phone: _____

Whom do you live with: _____

Occupation: _____ Hobbies: _____

Allergies (topical and internal): _____

Current medications and supplements:_____

_____

Nightly amount of sleep: _____ Weekly exercise:_____

Average stress level and causes: _____

_____

Do you smoke: _____ how much:_____ Weekly alcohol consumed: _____

Other alternative therapies you have experienced:_____

Please list your primary reasons for seeking CST: _____

_____

_____

Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (In parentheses are examples).

Skeletal/ bones (*broken bones, arthritis, osteoporosis, scoliosis, back pain*):_____

_____

Muscular, Connective Tissue/ muscles, joints (*sprains, bursitis, disc problems*): _____

_____

Eyes, Ears, Nose, Throat, Mouth (*TMJD, braces, hearing problems, speech, sinus, sore throats*):_____

_____

Are you wearing? ☐ contact lenses ☐ hearing aids ☐ dentures

Respiratory/ lungs (*asthma, bronchitis, frequent colds, pneumonia*): _____

_____

(please continue on other side)

Circulatory/ heart, arteries, veins, blood (*hypertension, varicose veins, bleeds or bruises easily*):_____

_____

Nervous System/ brain, nerves (*headaches, memory problems, concussions, seizures, ringing in ears, shooting pains, depression*):

_____

_____

Digestive & Elimination/stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*):_____

_____

_____

Skin (*rashes, psoriasis, eczema, warts*):_____

_____

Birth History (*what you know about your birth*):_____

_____

Endocrine/pituitary, hypothalamus, reproductive, thyroid (*hyperthyroid, diabetes*): _____

_____

FOR WOMEN ONLY:

Menstrual & Fertility History (*severe PMS, pregnancy complications, hysterectomy, fibroids*): _____ _____

_____

More details on anything described above or other significant factors (*family history, car accidents*): _____

_____

_____

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Oceana Bodywork Policies

Your signature below signifies acceptance of the following policies:

Health Information

I have filled out the Health History form completely and accurately to the best of my knowledge. I will keep Oceana Bodyworks informed of changes to my health or healthcare.

Oceana Bodyworks Scope of Practice

I understand that Oceana Bodyworks does not provide primary medical care, and recommends that I see my primary care doctor regularly and contact them for health care concerns. In case of emergency I will contact 911.

Client Confidentiality

Oceana Bodyworks does not sell client information. I understand that Oceana Bodyworks will not share any of my information with any persons or organizations unless 1) required by law to do so or 2) when necessary to consult with other health care professionals to provide optimal care.

Payment and Cancellation

Payment is expected at time of service. Cash, check, or Paypal are accepted.

A 48-hour notice is required for cancellation of an appointment, or I will be charged in full for the appointment. Oceana Bodyworks does not bill insurance companies for missed appointments or late cancellations. I am responsible for paying the missed appointment/late cancellation fees.

Privacy Practices

I have read, understand and been offered a copy Oceana Bodyworks' Private Practices Policy Form (the HIPPA).

Third Party Payment

I understand that, as a courtesy, Oceana Bodyworks bills my insurance directly. It is my responsibility to verify insurance coverage. If the insurance company denies payment or only provides a partial payment, I am responsible for the balance, deductible, and any co-pays. My signature below confirms my financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

I authorize and direct payment of medical benefits to Oceana Bodyworks for services provided by this office.

Release of Medical Records

I authorize the release of all of my medical records for the purpose of claims processing, to the following: my attorney, the healthcare providers attending to this condition, and insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through my attorney.

_____ _____

Client signature (or parent signature for children under 18) Date

Jana Panter
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