



## HEALING HEARTS BODYWORK

Patricia Angelina, C.M.T.  
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[www.healingheartsbodwork.com](http://www.healingheartsbodwork.com)

408-624-6167

It is my choice to receive bodywork. I agree to communicate with my practitioner any time I feel as though my well-being is being compromised. I have the right to stop services at any time if I'm feeling uncomfortable and wish to stop.

All bodywork performed at Healing Hearts Bodywork is **NON**-sexual. Practitioners have the right to refuse services or stop services at any time if they are feeling uncomfortable or unsafe. Full fees will be charged.

Draping is required for all clients. (Draping means being covered with a sheet.)

If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that bodywork practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations or perform surgical procedures. I acknowledge that bodywork 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.

I have stated all medical conditions that I am aware of and will update the bodywork practitioner of any changes in my health status.

There is a **24-hour cancellation policy** in place. I must give a minimum 24-hour notice to cancel or reschedule my appointment. With the lack of 24-hour notice, I will be charged half of the full fee for the scheduled services unless the practitioner is able to fill that appointment time with another client. The phone number to please call is: 408-624-6167.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Therapist: Patricia Angelina, C. M. T.

**PERSONAL HEALTH INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ **Referred**  
**by:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone - Day:  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone - Eve:  
\_\_\_\_\_

Email Address: \_\_\_\_\_ Birthday:  
\_\_\_\_\_

Occupation / Employer:  
\_\_\_\_\_

**\*Emergency contact:** \_\_\_\_\_ **Phone:**  
\_\_\_\_\_

Have you received massage before? \_\_\_\_\_ **If yes, how**  
**frequently?** \_\_\_\_\_

**HEALTH HISTORY/INFORMATION:**

Are you currently seeing a Doctor or Alternative health care practitioner?  
\_\_\_Yes\_\_\_No

Please explain if yes:  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently seeing a psychotherapist or attending regular support group  
meetings? \_\_\_ Yes \_\_\_ No

Please explain if yes:  
\_\_\_\_\_  
\_\_\_\_\_

**List current medications, including aspirin, ibuprofen, etc.:**  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries (past 5 years):**  
\_\_\_\_\_  
\_\_\_\_\_

**Accidents / Injuries / contagious diseases:**  
\_\_\_\_\_  
\_\_\_\_\_

**Please check any of the following pertaining to your health; circle if  
there are multiple choices:**

**CIRCULATORY / lung:**

\_\_\_\_\_ heart condition  
\_\_\_\_\_ varicose veins

**MUSCULO-SKELETAL:**

\_\_\_\_\_ bone or joint disease  
\_\_\_\_\_ tendonitis

\_\_\_\_\_ blood clots  
\_\_\_\_\_ high blood pressure  
(past 2 years)  
\_\_\_\_\_ low blood pressure  
\_\_\_\_\_ lymphedema  
\_\_\_\_\_ breathing difficulty  
\_\_\_\_\_ sinus problems  
\_\_\_\_\_ allergies  
\_\_\_\_\_ other?

\_\_\_\_\_ bursitis  
\_\_\_\_\_ broken / fractured bones  
\_\_\_\_\_ arthritis  
\_\_\_\_\_ sprains / strains  
\_\_\_\_\_ low back, hip, leg pain  
\_\_\_\_\_ neck, shoulder, arm pain  
\_\_\_\_\_ headaches / head injuries  
\_\_\_\_\_ spasms / cramps  
\_\_\_\_\_ jaw pain / TMJ

**NERVOUS SYSTEM:**

\_\_\_\_\_ herpes / shingles  
\_\_\_\_\_ numbness / tingling  
\_\_\_\_\_ chronic pain  
\_\_\_\_\_ fatigue

\_\_\_\_\_ lupus  
\_\_\_\_\_ other?

**INFECTIOUS DISEASE:**

\_\_\_\_\_ disease name(s):

\_\_\_\_\_ sleep disorders  
\_\_\_\_\_ other?

**OTHER Health Issues:**

\_\_\_\_\_ cancer / tumors

**REPRODUCTIVE:**

Are you pregnant? \_\_\_\_\_  
Stage \_\_\_\_\_  
disorders  
Due DaTe: \_\_\_\_\_

\_\_\_\_\_ diabetes  
\_\_\_\_\_ eating disorders  
\_\_\_\_\_ depression or other mood  
\_\_\_\_\_ drug / alcohol addiction

\_\_\_\_\_ PMS \_\_\_\_\_ Other?

\_\_\_\_\_ nicotine / caffeine addiction