Ricochet Body Solutions 5695 Hood Street, West Linn, OR 97068 503-318-9626 www.rbodysolutions.com

Confidential Health Summary

Contact Information

Name_____ DOB_____ Referred By_____
Address_____ Preferred Phone: _____ Cell? Y N
City_____ State____ Zip_____ Alternate Phone: Home/Work/Cell_____
Email_____
Occupation_____ Employer_____
Emergency Contact_____ Phone_____Relationship_____
Check the method(s) by which you prefer to be contacted for appointment reminders, schedule changes, or other needs: Preferred Phone____/Text____ Alternate Phone____/Text____ Email____ Mailing Address____
If you **do not** wish to receive monthly email newsletters from Ricochet Body Solutions, please check here: ____

Medical Provider Information

Physician_____ Phone_____ Other Provider_____ Phone_____
Please initial to grant your permission for consultation with your physician if needed for treatment. _____
A referral from your doctor may be required prior to receiving massage, cupping or Gua sha therapies.

Health History

How do you rate your overall health? ___Excellent ___Good ___Fair ___Poor
Review the list below. Please mark (X) for all conditions that apply now. Put a (P) for past conditions, an (F) for family history of illness. Pain Scale: minor-0 1 2 3 4 5 6 7 8 9 10-severe

____headaches, migraines	____asthma or lung conditions	____hepatitis, herpes, HIV/AIDS
____vision problems, vision loss	____heart, circulatory problems	____rashes, athletes foot
____ear problems, hearing loss	____high/low blood pressure	____skin allergies, sensitivities
____sinus problems, allergies	____blood clots, varicose veins	____bruise easily
____jaw pain, TMJ problems	____heart attack, stroke	____melanoma
____sleep difficulties	____diabetes	____cancer, tumors
____tension, stress	____abdominal or digestive problems	____bones: osteoporosis, bone injuries
____depression, fatigue	____hernia	____ligaments: sprains, tendonitis
____epilepsy, seizures	____constipation, diarrhea	____muscle: strains, tears
____numbness, tingling	____hormone problems	____joints: arthritis, joint pain, surgeries
____burning, stabbing pain	____pregnancy, ____weeks	____chronic pain, fibromyalgia
____spinal column disorders	____birth control, IUD	____alcohol, drug, substance abuse
____disc problems, spinal fusions	____mental, physical, sexual abuse	____other medical conditions not listed

Explain any areas noted above_____
_____
_____
_____
Current medications, including aspirin, ibuprofen, tylenol, herbs, supplements, etc._____
_____
_____
History of surgeries, car accidents, injuries including dates and treatment received_____
_____
_____
Please list all forms and frequency of stress reduction activities, hobbies, exercise, and/or sports participation_____
_____
_____

Current Concerns

Primary concern_____
_____
How long has this been an issue?_____
Cause of onset?_____
What have you done to treat this?_____

Secondary concern_____
_____
How long has this been an issue?_____
Cause of onset?_____
What have you done to treat this?_____

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Health Goals

Review the list below. Please rate 0-10 for your goals that apply now. Priority Scale: minor-0 1 2 3 4 5 6 7 8 9 10-major

___one-time quick fix	___decrease anxiety, depression	___increase range of motion, flexibility
___recover from injury	___reduce stress	___increase circulation of blood, lymph, nerves
___manage chronic pain	___improve moods, mental clarity	___improve body awareness & acceptance
___improve lifestyle	___have more energy	___decrease workout soreness
___age more gracefully	___improve sleep	___lose/gain weight
___eliminate bad habits	___improve digestion	___reduce facial wrinkles, skin issues
___reduce sinus congestion	___improve posture	___relieve jaw, facial muscle tension
___reduce lung congestion	___reduce cellulite	___reduce frequency/intensity of headaches, migraines

___other_____

Ricochet Body Solutions Office Policies and Consent to Receive Treatment

Please be advised of the policies for this office. Your signature below signifies understanding and acceptance of these policies. Failure to adhere to the policies of this office may result in termination of any session(s) at any time. Each of these documents may be found at www.rbodysolutions.com/services/.

Please Initial Each:

____I have been offered, and/or received, AND READ Ricochet Body Solutions' Office Policies Rev. 2023-08-31 and AGREE TO ABIDE BY THESE POLICIES.

____I have been offered, and/or received, AND READ Ricochet Body Solutions' Consent to Receive Treatment Revised 2023-08-31 and AGREE TO ABIDE BY THESE TERMS.

Your cooperation is essential to a successful therapeutic program. If you do not understand any of the above policies, please share your questions via email or during our intake consultation, so they can be clarified before you begin treatment. I appreciate the opportunity to help you and welcome your suggestions as to how I may improve my service to you.

Client Name_____

Client Signature_____ Date_____

Consent to Treatment of Minor: By my signature below, I authorize Rachel Climer, LMT to administer massage therapy/bodywork to my child or dependent _____ as she deems necessary.

Signature of Parent or Guardian_____ Date_____