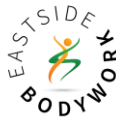


Eastside Bodywork LLC
Injury and Pain Resolution
Mindset Coaching
WA License # MA 60486695

Welcome to Eastside Bodywork!

Please fill out the forms in this package and bring them with you to your appointment. If you are unable to fill out the forms at home, please plan on arriving 15 minutes before your scheduled appointment time.

The office is located at: **2340 130th Ave NE, Building D, Suite 200 (inside Ohana Wellness)**
Bellevue WA 98005
Contact: (425) 236-9900 or simone@eastsidebodywork.com
The office complex is called Northup North, and Building D is at the rear left side of the complex. Suite 200 is on the 2nd floor and accessible via elevator.
There is ample free parking outside the building.

Please have a seat in the waiting room. I will come and get you for your appointment.

Manual Neurotherapy sessions – No lotion/Fully clothed:

Neuromuscular modalities are being applied as 'dry modalities' (no oil or lotion is being used) while you are fully clothed. Please do not wear any body lotion or oils on the day of your session!

I ask that you to bring appropriate, loose fitting clothing to the appointment. For instance, women can wear a sports bra, bathing suit top, or tank top along with a loose-fitting pair of athletic shorts, or a bathing suit bottom. A loose-fitting T-shirt can also be worn if you don't mind it getting stretched out a bit. Men are usually comfortable in just a pair of loose-fitting shorts. If you have specific concerns in this area, please do not hesitate to let me know. Draping is always an option!

Mindset Coaching sessions/Neuroemotional work

Coaching sessions are held in-person in my office or via video call online. If we meet in person, you will typically be seated in a comfortable chair or occasionally be lying down on a massage table.

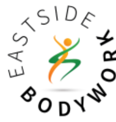
Policies

Cancellation:
Please **let me know 48 hours prior to your scheduled appointment if you need to cancel**. This gives me the opportunity to offer your spot to another client. **Cancellations with less than 48 h notice and no-shows will result in full service charges or voidance of gift certificates.**

COVID-19: I care about the safety of my clients. That is why I ask you to reschedule if you are sick. If you show up and I decide that your condition/symptoms may be a health hazard for other customers and/or myself, I reserve the right to refuse service. If you experience symptoms of a common cold, I still ask you to reschedule. During these uncertain times I am electing to err on the side of caution to be especially careful with your health as well as my own. I appreciate your understanding.

Arriving late:
Appointment times have been arranged specifically for you. If you arrive late, your session may have to be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, I will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the full session that you had originally booked.

Payment: Full payment is due at the time of treatment. I accept cash, check, and credit cards.



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Health History Form

An accurate health history is important to ensure that it is safe for you to receive treatment. All information gathered is kept confidential except as required or allowed by law. You will be asked to provide written authorization for the release of any information.

Basic Information

Name: ______________________________

Address: ______________________________

City: ____________________ Postal Code: __________

Who referred you? ______________________________

Primary Physician: ______________________________

Physician Phone Number: ________________________

Occupation: ______________________________

Today's Date: ______________________________

Date of Birth: ______________________________

Phone Number: ______________________________

Email address: ______________________________

Emergency Contact: ______________________________

Emergency Contact #: ______________________________

Recreational Activities: ______________________________

General Health Status: POOR FAIR GOOD EXCELLENT

What can I help you with?

Primary Complaint: ______________________________ Since ______________

Pain level today: 0 1 2 3 4 5 6 7 8 9 10

Secondary Complaint: ______________________________ Since ______________

Pain level today: 0 1 2 3 4 5 6 7 8 9 10

What are your goals for treatment?
(What would you like to accomplish/be able to do again?)

____

____

Previous Treatment

Did you seek treatment for this condition before? Y ❑ N❑

If yes, what types of care did you seek?

____

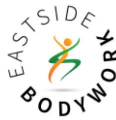
Are you physically active? Y ❑ N❑

How often and type of activity? ______________________________

Good Sleeping Habits? Y ❑ N❑

Regular Eating Habits? Y ❑ N❑

General Stress Level High ❑ Medium ❑ Low ❑



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Health History

Please indicate all current/ongoing (C/O) and past conditions you have experienced

Head/Neck	C/O	Past
Whiplash	☐	☐
Headaches	☐	☐
Migraine	☐	☐
Concussion	☐	☐
Ringing in the Ears	☐	☐
Hearing Loss	☐	☐
Vision Problems	☐	☐
Brain Injury	☐	☐
TMD (Jaw Pain)	☐	☐

Other: ______________________________

Respiratory/Lungs	C/O	Past
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Shortness of Breath	☐	☐
Sinusitis	☐	☐
Frequent Colds	☐	☐
Recurrent Lung Infection	☐	☐
Chronic Cough	☐	☐

Family History of Above: ______________
Other: ______________________________

Digestive	C/O	Past
Constipation	☐	☐
Diarrhea	☐	☐
Crohn's Disease/Colitis	☐	☐
Irritable Bowel Syndrome	☐	☐
Ulcers	☐	☐
Diverticulitis	☐	☐
Nausea	☐	☐
Celiac Disease	☐	☐

Other: ______________________________

Cardiovascular	C/O	Past
High Blood Pressure ___/____	☐	☐
Low Blood Pressure ___/____	☐	☐
Heart Attack	☐	☐
Chronic Congestive Heart Failure	☐	☐
Chest Pain/Angina	☐	☐
Stroke	☐	☐
Pace Maker or Similar Device	☐	☐
Phlebitis	☐	☐
Hemophilia	☐	☐
Heart Disease	☐	☐
Poor Circulation	☐	☐
Congestive Heart Failure	☐	☐

Other: ______________________________

Nervous System	C/O	Past
Spinal Cord Injury	☐	☐
Numbness/Tingling	☐	☐
Sensory Change/Loss	☐	☐
Sciatica	☐	☐
TOS	☐	☐
Seizures	☐	☐
Multiple Sclerosis	☐	☐
Cerebral Palsy	☐	☐
Epilepsy	☐	☐
Carpal Tunnel	☐	☐
Muscular Dystrophy	☐	☐

Other: ______________________________

Infections	C/O	Past
Hepatitis	☐	☐
Type:	___________	
Infectious Skin	☐	☐
Conditions	☐	☐
TB	☐	☐
HIV	☐	☐

Other: ______________________________

Disease/Condition	C/O	Past
Cancer (Benign/Malignant)	☐	☐
Type/Location: ______________		
Treatment: ______________		
Fibromyalgia	☐	☐
Chronic Fatigue Syndrome	☐	☐
Allergies	☐	☐
Diabetes (Type?) ___________		
Onset: ______________		

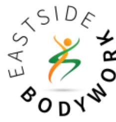
Other: ______________________________

Skin	C/O	Past
Eczema	☐	☐
Dermatitis	☐	☐
Acne	☐	☐
Frostbite	☐	☐
Psoriasis	☐	☐
Sensitive Skin	☐	☐
Rash/Eruptions	☐	☐
Cold Sores	☐	☐
Herpes	☐	☐

Other: ______________________________

Bone/Joint	C/O	Past
Dislocation	☐	☐
Fracture	☐	☐
Arthritis (RA/OA)	☐	☐
Family History of Arthritis:	☐	☐
Degenerative Disc Disease	☐	☐
Prolapsed/Herniated Disc	☐	☐
(location of herniation): ___________		

Other: ______________________________



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Soft Tissue Joint Discomfort or Pain	C/O	Past
Head/Jaw	☐	☐
Neck	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Wrist/Hand	☐	☐
Back	☐	☐
Hips	☐	☐
Legs	☐	☐
Knees	☐	☐
Ankles/Feet	☐	☐
Tendonitis	☐	☐
Strain/Sprain	☐	☐
Poor Posture	☐	☐

Other: ______________________________

Women Only	C/O	Past
Pregnancy	☐	☐
Weeks Pregnant:	______________	
# of Children:	______________	
Vaginal Birth(s):		☐
Episiotomy/Tearing:	☐	☐
C-Section(s):		☐

Other: ______________________________

Do you perform any repetitive movement in your work/sport/hobby? Y ❑ N❑

If yes, describe ____

Do you sit for long hours at a time? Y ❑ N❑

If yes, describe ____

Do you experience excessive stress in your work, family or any other aspect of your life? Y ❑ N❑

If yes, describe ____

Do you exercise regularly and/or participate in any sports? Y ❑ N❑

If yes, what kind of exercise/sports? ____

Please list any medications you are currently taking and what condition they treat:

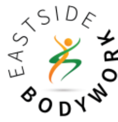
______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

List any known allergies: ____

____



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Please list ALL accident(s) you have had in your life (even if they seem unrelated to your primary or secondary complaint). **This includes car accidents, falls, body impacts (e.g. from sports) or any other trauma:**

____

____

____

____

____

____

Please list ALL surgeries you have had in your life (no matter how long ago or how small the scar):

____

____

____

____

____

____

Please list ANY other scars you have on your body (even small scars such as from mole removals):

____

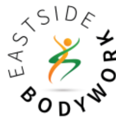
____

____

____

____

____



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		When?
Have you ever been intubated?	Y ❑ N❑	______
Have you ever suffered from whiplash?	Y ❑ N❑	______
Did you ever fracture a bone?	Y ❑ N❑	______
Did you ever tear a ligament?	Y ❑ N❑	______
Do you have a history of ankle sprains?	Y ❑ N❑	______
Do you clench your jaw?	Y ❑ N❑	______
Do you have food allergies/sensitivities?	Y ❑ N❑	______
		______

How is your digestion? Regular ❑ Irregular ❑ Constipated ❑ Diarrhea ❑

When you wake up in the morning are you feeling Refreshed ❑ Exhausted ❑

Mid-afternoon are you feeling Fine ❑ Exhausted ❑

Have there been times of extreme/exceptional stress in your life? If so, when?

______

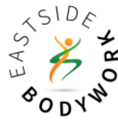
______

______

Is there anything else I should know about you or your medical history?

______

______



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Please indicate all areas of pain (///), tension(zzz) and <u>all</u> SCARS (--) on the shapes below.

Is there anything you would like to add or clarify?

____

____

____

____

____

I understand that the soft-tissue therapy I receive is provided for the purpose of muscular tension relief, stress reduction, improvement of circulation, and relaxation. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that the services offered today and in the future are not a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions on the intake form and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that all massage therapy and bodywork offered is strictly non-sexual. I also understand that ANY illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand that full payment is due at the time of treatment. I agree to give 48 hours notice of cancellation for any appointment I have scheduled. If less than 48 hours notice is given, I understand that the full payment will be charged for the missed appointment. Cases of extreme emergency are considered exceptions.

I have carefully read and understood all of the above and have answered all questions fully and accurately.

____ ____________________

Signature of client Date

VIDEO/PHOTOGRAPHY CONSENT FORM: Treatment at Eastside Bodywork may include the capture of video or still photography to document client's progress (posture, range of motion, movement) and may serve as supporting material for self-care exercises at home (movement instruction). **Videos and/or still photographs will never be shared with anybody other than the client and the therapist unless specific permission is granted by the client**.

Consent to be videotaped/photographed: ____

Signature of client

I do **NOT** wish to be photographed or videotaped. ☐

____

Signature of therapist