

BODY DYNAMICS, INC.

- ♦ Manual, Orthopaedic, and Performing Arts Physical Therapy ♦
- ♦ Polestar® Certified Pilates-based Rehabilitation and Conditioning ♦

Massage Therapy General Information

Date: _____ How did you hear of us? _____

Name: Last: _____ First: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ SSN: _____

Phone: Home: _____ Work: _____

Other: _____ E-Mail: _____ @ _____

Emergency Contact Name: _____ Phone: _____

Financial Policy

1. All payments must be made at the time of service. BDI accepts cash, checks, and the following credit cards: VISA, Mastercard, Discover, and American Express.
2. **Cancellation policy:** Because of limited times available and high demand, it is necessary to enforce a strict cancellation policy.
 - a. If a client cancels at least 24 hours prior to the appointment, there is no charge.
 - b. If a client cancels less than 24 hours prior to the appointment or does not show, the client will be charged a fee that is equivalent to the cost of one full session.
3. **Late Policy:** BDI strives to give you our fullest attention during your allotted time. Your respect of other client's time is appreciated and sessions will end promptly as scheduled. Late arrivals are responsible for the full fee of the session. If a patient is more than 15 minutes late, we reserve the right to reschedule.

Please initial that you have read and understand our cancellation policy _____

4. **Tip Policy:** BDI does not accept tips. If you decide to tip, the money will be contributed to our quarterly charitable organization.
5. **Insurance Policy:** If you wish to submit your message to insurance or FSA, BDI can supply you with an itemized statement to do so. BDI will not submit to any insurance for massage services and will not provide a insurance form for the client to submit.

Fee Schedule

60 minutes	\$100.00
45 minutes	\$78.00
30 minutes	\$56.00

Package Rates:

*10 one hour massage sessions (must be used within 6 months of purchase) \$900.00

* All package purchases are final. No refunds will be issued.

Client Date

Witness Date

Name: _____ Age: _____

Occupation: _____

Typical Leisure/Fitness Activities: _____

Medical History

General Health (check one): ___Excellent ___Good ___Fair ___Poor

Have you had any **medical problems, surgery, or hospitalization** in the past year (circle)?

Yes No

If "yes", please specify: 1. _____
2. _____
3. _____

Prescriptions Medications: _____

Over-the-counter Medications: _____

Tobacco use? Yes No

If yes, please specify ppd: _____ years: _____

Alcohol (circle): Yes No If yes, please specify amount/day: _____
amount/wk: _____
amount/mo: _____

Caffeine Yes No # drinks/day _____

Illicit Drugs Yes No # days/wk _____

Present/past medical conditions:

(Check all that apply. Describe condition in space provided.)

Allergies _____

Skin Conditions _____

Neurological Conditions _____

Cardiovascular Conditions _____

Diabetes/Circulatory Problems _____

Arthritis _____

Cancer/Tumors _____

Sensory Deficits _____

Additional Comments: _____

OVER →

Present Injuries/Problems (if applicable):

Date of Injury/Onset: _____ Body Part(s): _____

Mechanism of Onset: _____

