



Sari Lewis, OTR/L, RCST®

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Phone: (480) 206-6592

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Personal Health Information

Name: _____ Birth Date: _____ Date: _____

Address: _____ Daytime Phone: () _____

City/State/Zip: _____ Evening Phone: () _____

Email: _____ Cell Phone: () _____

Referred by: _____

Occupation/Employer: _____

Primary Health Care Provider/Doctor: _____ Phone: () _____

Permission to consult with primary provider? Please initial. Yes _____ No _____

Emergency Contact/relationship: _____ Phone: () _____

Treatment History

What types of body work have you received in the past? _____

When was your last session of bodywork? _____

What results do you want from your Wellness visit? _____

Prioritize the areas of your body that you would prefer to have treated: _____

Are you currently seeing a medical practitioner? Please explain: _____

Are you currently seeing a psychotherapist or are you attending regular support group meetings?
Please explain: _____

List stress reduction/exercise activities and frequency: _____

List current medications, including aspirin, Ibuprofen, etc: _____

(Please proceed to page 2)

Previous History (Include year and treatment received)

Surgeries/Accidents/Injuries: _____

Health History (Please describe history of medical conditions and current status)

Musculo-skeletal: _____

Skin: _____

Digestive: _____

Circulatory: _____

Nervous System: _____

Reproductive: _____

Infectious disease: _____

Other: _____

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

Signature: _____ **Date:** _____

I agree to be financially responsible at the time of service for the full cost of Wellness Visits with Sari Hands PLC. **I will not, nor will Sari Hands PLC bill my insurance company for the services.**

I realize that Wellness Visits are separate from Occupational or Physical Therapy services. **If I am under care in another therapy program, I will inform my therapist prior to scheduling my visit.**

I agree to hold Sari Hands PLC harmless from any claims, demands, injuries, damages or actions resulting from participation in a Wellness Program with Sari Hands PLC

I also realize that appointments are to be scheduled at a mutually convenient time.

Patient Signature

Date