Sari Lewis, OTR/L,RCST®

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www.sarihands.com

Phone: (480) 206-6592 Fax (480) 451-1352

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**