## Sari Lewis, OTR/L,RCST®

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**Scottsdale, AZ 85260**
**www.sarihands.com**

**Phone: (480) 998-8448** **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**