INTEGRATIVE BODYWORK, INC

NEW CLIENT INFORMATION

DATE _____ DOB _____

CLIENT NAME LAST _____ FIRST _____ MI _____

EMAIL _____ PRIMARY PHONE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BEST TIME AND PLACE TO REACH YOU _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX - M_____ F_____ AGE _____ BIRTH DATE _____ MINOR_____

MARRIED_____ WIDOWED_____ SINGLE_____ SEPARATED_____ DIVORCED_____ PARTNERED_____

OCCUPATION _____

CLIENT EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY, CONTACT

NAME _____ RELATIONSHIP _____ PRIMARY PHONE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ NAME OF INSURED _____

EMPLOYER _____ MEMBER ID _____

ADDRESS _____ GROUP # _____

CITY _____ STATE ____ ZIP _____ PHONE _____

Jim Fazio, LMT, CSI, UTP
321~432~0775
jfhands@aol.com

Integrative Bodywork, Inc
4083 South US Highway 1, Suite 102
Rockledge, Florida 32955

www.jimfazioib.com

CLIENT CONDITION

Reason for visit_____

What are the three most traumatic things you have experienced?

1- _____

2- _____

3- _____

When did your symptoms first appear?_____

Are your symptoms due to: ___ Accident ___ Trauma ___ Injury ___ Accumulated Stress

What was going on in your life when symptoms were first apparent? _____

_____

Were you under any additional stress at the time of the accident/trauma/stressful event with:

___ Family ___ Work ___ Finances ___ Other

Were there any lasting physical or emotional effects after the accident/trauma/stressful event such as:

___ Tension ___ Pain ___ Numbness ___ Shallow Breathing
___ Fearful Thoughts ___ Sleep Difficulty ___ Digestive Problems ___ Other

Does it interfere with your ___Work ___ Daily Routine ___ Recreation ___ Other

How often do you have this pain? _____

Is it constant or does it come and go?_____

Is this condition getting progressively worse? _____

Has the location and/or intensity changed?_____

Does any position, stretch or movement give you relief?

_____

Are heat or cold packs helpful? _____

Do you have problems sleeping? ___ Going to sleep ___ Staying asleep

Activities/movements that is painful to perform ___ Sitting ___ Standing ___ Walking
___ Bending ___ Lying Down

Yes No

_____ _____ Do you associate any of your pain with stressful situations in your life?

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Yes No

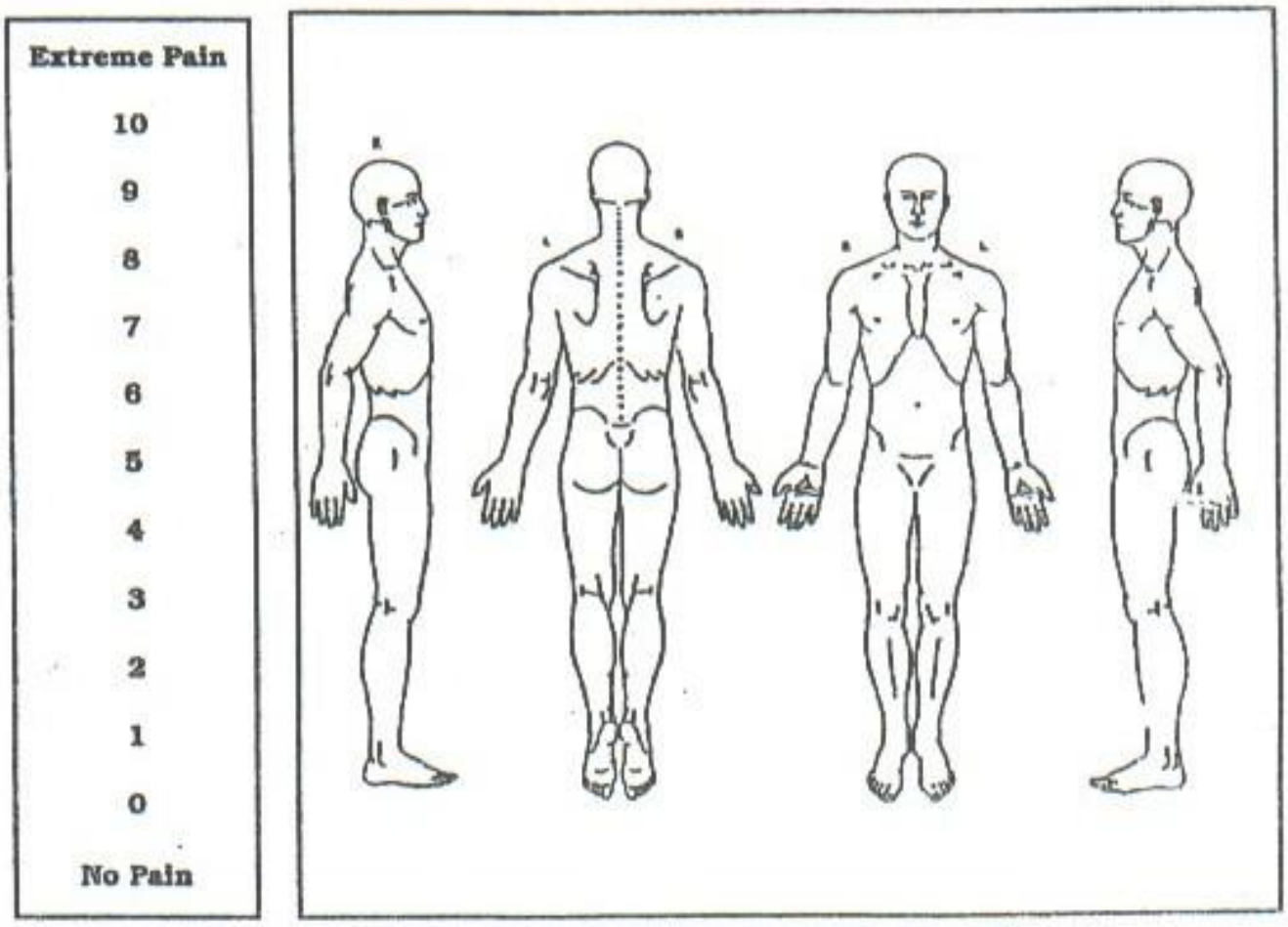
_____ _____ Do you associate any of your pain with the way you think about things ~ your thought processes?

_____ _____ Do you associate any of your pain with how you process your feelings or emotions? For example, holding in your feelings?

Exactly where is your pain most severe?

Mark on the picture below where you continue to have pain, numbing or tingling and rate the severity of your pain according to the scale below where 1 is least pain and 10 is severe pain.

For example – if you have severe pain in the back of your neck (2nd figure) place a "10" in that box.



What treatment have you already received for your condition?

___Medications ___Surgery ___Physical Therapy ___Chiropractic ___None ___Other _____

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STRESS EVALUATION QUESTIONNAIRE

Social Readjustment Rating Scale

Stress is cumulative, so to estimate the total stress you are experiencing, circle Yes or No and add up the values corresponding to the **events that have occurred in your life over the past year**.

If a particular event has happened to you more than once within the last 12 months, multiply the value by the number of occurrences.

Life event	Answer	Life change units	Points
Death of a spouse	Yes No	100	
Divorce	Yes No	73	
Marital separation	Yes No	65	
Imprisonment	Yes No	63	
Death of a close family member	Yes No	63	
Personal injury or illness	Yes No	53	
Marriage	Yes No	50	
Dismissal from work	Yes No	47	
Marital reconciliation	Yes No	45	
Retirement	Yes No	45	
Change in health of family member	Yes No	44	
Pregnancy	Yes No	40	
Sexual difficulties	Yes No	39	
Gain a new family member	Yes No	39	
Business readjustment	Yes No	39	
Change in financial state	Yes No	38	
Death of a close friend	Yes No	37	
Change to different line of work	Yes No	36	
Change in frequency of arguments	Yes No	35	
Mortgage or Loan over $100,000	Yes No	32	
Foreclosure of mortgage or loan	Yes No	30	
Change in responsibilities at work	Yes No	29	

Life event	Answer	Life change units	Points
Child leaving home	Yes No	29	
Trouble with in-laws	Yes No	29	
Outstanding personal achievement	Yes No	28	
Spouse starts or stops work	Yes No	26	
Begin or end school	Yes No	26	
Change in living conditions	Yes No	25	
Revision of personal habits	Yes No	24	
Trouble with boss	Yes No	23	
Change in working hours or conditions	Yes No	20	
Change in residence	Yes No	20	
Change in schools	Yes No	20	
Change in recreation	Yes No	19	
Change in church activities	Yes No	19	
Change in social activities	Yes No	18	
Minor mortgage or loan	Yes No	17	
Change in sleeping habits	Yes No	16	
Change in number of family reunions	Yes No	15	
Change in eating habits	Yes No	15	
Vacation	Yes No	13	
Christmas	Yes No	12	
Minor violation of law	Yes No	11	

TOTAL POINTS: _____

Score 150 or less: 37% chance of illness within the next 2 years.

Score of 150-299: 50% chance of illness within the next 2 years.

Score of 300 or above: 80% chance of illness within the next 2 years.

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CONSENT FOR THERAPY

1. The course of the session will be determined by your needs at the time of the appointment. There will be a brief consultation at the beginning of the session to determine those needs.
2. This work is intended for stress reduction, self education, postural alignment and enhancing the body's self healing re~regulating mechanisms. It is not medical in nature and is not a substitute for medical attention when needed. You acknowledge your responsibility for consulting a doctor when it is appropriate.
3. Your permission and consent is requested to apply those techniques which are appropriate in helping you establish balance in your body.
4. In the course of this session, it is possible that uncomfortable sensations may occur. It is important that you express any feelings of discomfort so that we may work together.
5. When we make an appointment, it is an agreement. Please allow at least 24 hours notice if you need to reschedule to avoid a cancellation fee.
6. I understand that payment is due at the time of our appointment unless other agreements have been made.
7. I fully acknowledge my own responsibility for consulting a qualified physician for any physical ailment.
8. HIPPA Statement – A copy of our HIPPA Statement is available on our website at http://www.jimfazioib.com/New_Client_Information or a copy can be obtained at this office upon request. Your signature below acknowledges that you have received and read the HIPPA statement.
9. I give Jim Fazio, my Licensed Massage Therapist, full permission to legally consult with his professional health care mentors in efforts to assist with my healing.

Client Name _____ Date _____

Parent, Guardian or Client's Legal Representative _____

Signature _____

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HIPPA ACKNOWLEDGEMENT

Protecting Your

Confidential Health Information

Is Important To Us

Notice of Privacy Practices

Client Acknowledgment

Thank you very much for taking time to review our HIPPA Statement and how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging that the terms have been read and understood.

Client Name

Date

Client, Guardian or Client's Legal Representative

Signature

List below the names and relationship of people to whom you authorize Integrative Bodywork, Inc to release PHI:

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FINANCIAL RESPONSIBILITY

1- Please read and sign this form before your initial session.

2- Full payment is due at the time of service.

3- You may use your medical insurance, but we will call the insurance company to verify your benefits. We will file insurance claims to your company however, if service is denied, is not a covered service, or if you are found to have a deductible or co-insurance amount, you will be responsible for paying your co-payment or your balance at the time of your appointment.

4- Sometimes the insurance will deny services. If this occurs, you as the client are responsible for payment. We are sensitive to this issue and we will try to warn you if we feel a service may not be covered. Ultimately the insurance contract is between you, your employer and your insurance company.

5- We do not mail invoices or statements to clients for balances. If we receive notice that there is a balance on your account, payment will be due immediately. Please refer to your EOB from your insurance company for the balance.

6- CASH clients are required to pay the full amount at the time of service. We also accept credit card payments.

7- We will charge a fee of $30.00 per any return checks, for uncollected funds or NSF.

8- You will be charged for the **full amount** of your appointment if your do not cancel 24 hours prior to your scheduled appointment. This amount must be paid in full prior to your next scheduled appointment.

Client Name

Date

Client, Guardian or Client's Legal Representative

Signature

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CANCELLATION POLICY

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, car problems and illness are just a few reasons why one might consider cancelling an appointment.

In our desire to be effective and fair to all of our clients, and out of consideration for your therapist's time, we have adopted the following policies:

CANCELLATIONS

- **24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us 24 hours advance notice, you will be charged for the **full amount** of your appointment. This amount must be paid in full prior to your next scheduled appointment.

NO-SHOWS

Anyone who either forgets or consciously chooses to forgo their appointment without the appropriate notice for whatever reason will be considered a "no-show". You will be charged the full amount for your missed appointment and future service will be denied until payment is made in full.

ARRIVING LATE

- Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours.
- Depending upon how late you arrive, your therapist will determine if there is sufficient time remaining to start your session.

Regardless of the length of the session actually given, if given at all, you will be responsible for payment of a "full" session.

Please note that there is a high demand for this nervous system re~regulation therapy. Out of respect and consideration to your therapist and our other clients, kindly plan accordingly and be on time.

Client Name _____ Date _____

Client, Guardian or Client's Legal Representative _____

Signature _____

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