



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 _____

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Integrative Bodywork, Inc
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Rockledge, Florida 32955

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.

Extreme Pain

10

9

8

7

6

5

4

3

2

1

0

No Pain

What treatment have you already received for your condition?

___ Medications ___ Surgery ___ Physical Therapy ___ Chiropractic ___ None ___ Other _____



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	Life event	Answer	Life change units	Points
Death of a spouse	Yes No	100		Child leaving home	Yes No	29	
Divorce	Yes No	73		Trouble with in-laws	Yes No	29	
Marital separation	Yes No	65		Outstanding personal achievement	Yes No	28	
Imprisonment	Yes No	63		Spouse starts or stops work	Yes No	26	
Death of a close family member	Yes No	63		Begin or end school	Yes No	26	
Personal injury or illness	Yes No	53		Change in living conditions	Yes No	25	
Marriage	Yes No	50		Revision of personal habits	Yes No	24	
Dismissal from work	Yes No	47		Trouble with boss	Yes No	23	
Marital reconciliation	Yes No	45		Change in working hours or conditions	Yes No	20	
Retirement	Yes No	45		Change in residence	Yes No	20	
Change in health of family member	Yes No	44		Change in schools	Yes No	20	
Pregnancy	Yes No	40		Change in recreation	Yes No	19	
Sexual difficulties	Yes No	39		Change in church activities	Yes No	19	
Gain a new family member	Yes No	39		Change in social activities	Yes No	18	
Business readjustment	Yes No	39		Minor mortgage or loan	Yes No	17	
Change in financial state	Yes No	38		Change in sleeping habits	Yes No	16	
Death of a close friend	Yes No	37		Change in number of family reunions	Yes No	15	
Change to different line of work	Yes No	36		Change in eating habits	Yes No	15	
Change in frequency of arguments	Yes No	35		Vacation	Yes No	13	
Mortgage or Loan over \$100,000	Yes No	32		Christmas	Yes No	12	
Foreclosure of mortgage or loan	Yes No	30		Minor violation of law	Yes No	11	
Change in responsibilities at work	Yes No	29					

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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THE GENERALIZED ANXIETY DISORDER SCALE

CLIENT NAME: _____

DATE: _____

Instructions: Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score _____ = Add Columns _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all

Somewhat difficult

Very difficult

Extremely Difficult

8. How often have you felt worried and stressed out in the past month? _____

9. What's been causing you to feel stressed out? _____

10. How long has this been going on? _____

11. How has the stress been affecting you and your relationships? performance at work? any other effects?
_____12. What have you been doing to cope with the stressful situation? How well has that been working for you? How can others help you such as your support group?

Total Score	Interpretation
>= 10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

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MUSCULOSKELETAL BOURNEMOUTH QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Instructions: The following scales have been designed to find out about your painful complaint & how it is affecting you. Please answer ALL the scales and mark the ONE number on EACH scale that best describes how you feel.

13. Over the past few days, on average, how would you rate your pain?

No pain _____ Worst pain possible
0 1 2 3 4 5 6 7 8 9 10

14. Over the past few days, on average, how has your complaint interfered with your daily activities (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair, sleeping)?

No interference _____ Unable to carry on with normal daily activity
0 1 2 3 4 5 6 7 8 9 10

15. Over the past few days, on average, how much has your painful complaint interfered with your normal social routine including recreational, social and family activities?

No interference _____ Completely unable to participate in any social and recreational activity
0 1 2 3 4 5 6 7 8 9 10

16. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?

Not at all anxious _____ Extremely anxious
0 1 2 3 4 5 6 7 8 9 10

17. Over the past few days, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?

Not at all depressed _____ Extremely depressed
0 1 2 3 4 5 6 7 8 9 10

18. Over the past few days, how do you think your work (both inside the home and/or employed work) have affected your painful complaint?

Make it no worse _____ Make it much worse
0 1 2 3 4 5 6 7 8 9 10

19. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own?

I can control it completely _____ No control whatsoever
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:



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:



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



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.

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Date

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