Client Intake Form

PERSONAL INFORMATION (*Please Print Clearly*)

Name Date of Birth

Home Address

City State Zip code

Home phone Cell phone

Work phone Ext.

Email

Occupation

Marital Status (Circle one) S M W D

Referred by

Emergency contact (Name) Emergency contact phone

Physician's name Physician's contact

MEDICAL INFORMATION

Please answer the following questions as accurately and specifically as possible in order for me to create treatment sessions that will meet your individual needs

Reasons for initial visit (primary and secondary complaints):

Please describe nature of your pain, limited range of motion or difficulty with activities due to your symptoms:

When and how did your symptoms begin?

Have you received one of the following treatments for this condition? (If Yes, circle one, specify how often and if it was helpful):

1. Myofascial Release:

2. Physical Therapy:
3. Chiropractic:
4. Other:

Please list the history of **ALL** past surgeries, accidents, traumas (physical or emotional):

List **ALL** medications you are currently taking:

List any known allergies/reactions:

Please check any of the conditions you've had in the past or currently have:

Musculoskeletal Bone or joint disease Tendonitis/Bursitis Arthritis/Gout Jaw Pain (TMJ) Lupus Spinal Problems Migraines/Headaches Osteoporosis

Circulatory Heart Condition Phlebitis/Varicose Veins Blood Clots High/Low Blood Pressure Lymphedema Thrombosis/Embolism

Respiratory Breathing Difficulty/Asthma Emphysema Allergies, specify:

Sinus Problems

Nervous System Shingles Numbness/Tingling Pinched Nerve Chronic Pain Paralysis Multiple Sclerosis Parkinson's Disease

Reproductive Pregnant, stage _______________ Ovarian/Menstrual Problems Prostate

Skin Allergies, specify:

Rashes Cosmetic Surgery Athlete's Foot Herpes/Cold Sores

Digestive Irritable Bowel Syndrome Bladder/Kidney Ailment Colitis Crohn's Disease Ulcers

Psychological Anxiety/Stress Syndrome Depression

Other Cancer/Tumors Diabetes Drug/Alcohol/Tobacco Use Contact Lenses Dentures Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above:

Do you exercise regularly and/or participate in any sports? If yes, what kind of exercise/sports?:

Do you perform any repetitive movement in your work, sports or hobby? If yes, describe:

What are your goals for treatment?

CLIENT HEALTH RELEASE AND AGREEMENT

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/ HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY THERAPIST IMMEDIATELY.

I am aware of the benefits and risks of therapy and give "Bodywork and Myofascial Therapy" consent to provide therapeutic services as ordered by my physician or as requested by myself. I acknowledge that myofascial therapy is not a substitute for medical care, medical examination or diagnosis, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that is beyond the scope of practice of my therapist. I understand that bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because myofascial release/ massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

Client Signature **Date**

Signature of Parent or Guardian to treat a minor

PLEASE INDICATE AREAS OF PAIN, TENSION AND/OR DYSFUNCTION.

Draw or highlight to show where you feel pain or tension, have limited range of motion, or areas that create dysfunctional symptoms