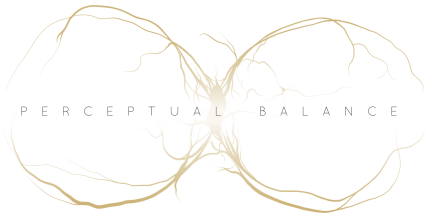

New Client Intake

Name:_____

Phone number:_____

Email:_____

Emergency Contact:

First Name _____ Last Name _____

Relationship to you _____ Phone _____

What brings you in today?

Describe sensations if it's a specific area.

Tell me about the event in which you started feeling that sensation(s).

When in the day does it bother you? Or specific movement/posture?

What relieves it?

Are you allergic to any oils? ☐ Yes ☐ No

Please circle your stress level: Low 1 2 3 4 5 High

Are you presently taking any medication? ☐ Yes ☐ No

Please explain:

Have you ever had surgical procedure or stitches? ☐ Yes ☐ No

Please explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue? ☐ Yes ☐ No

Please explain:

Check all the following conditions that apply to you, past and present.

Musculo-Skeletal Conditions

- ☐ Headaches
- ☐ Strains/sprains
- ☐ Leg, foot pain
- ☐ Problems walking
- ☐ Tendonitis
- ☐ Scoliosis
- ☐ Joints stiffness/swelling
- ☐ Broken/fractured bones
- ☐ Chest, ribs, abdominal pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Bursitis
- ☐ Other _____
- ☐ Spasms/cramps
- ☐ Back, hip pain
- ☐ Osteoporosis
- ☐ Jaw pain/TMJ
- ☐ Arthritis

Circulatory/Respiratory Conditions

- ☐ Dizziness
- ☐ Cold feet or hands
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Cold sweats
- ☐ Allergies
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Stroke
- ☐ Asthma
- ☐ Other

Digestive Conditions

- ☐ Indigestion
- ☐ Diarrhea
- ☐ Colitis
- ☐ Intestinal gas/bloating
- ☐ Irritable bowel syndrome
- ☐ Other _____
- ☐ Constipation
- ☐ Crohn's Disease

Nervous System Conditions

- ☐ Numbness/tingling
- ☐ Ulcers
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Other _____
- ☐ Fatigue
- ☐ Parkinson's Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Muscular Dystrophy
- ☐ Sleep disorders
- ☐ Herpes/shingles
- ☐ Epilepsy
- ☐ Paralysis

Reproductive System Conditions

- ☐ Pregnancy
- ☐ Other _____

Skin Conditions

- ☐ Rashes
- ☐ Acne
- ☐ Allergies
- ☐ Impetigo
- ☐ Athlete's Foot
- ☐ Other _____

Other Conditions

- ☐ Loss of Appetite
- ☐ Hearing impaired
- ☐ Fibromyalgia
- ☐ Tuberculosis
- ☐ Difficulty concentrating
- ☐ Visually impaired
- ☐ Post/Polio Syndrome
- ☐ Other _____
- ☐ Depression
- ☐ Diabetes
- ☐ Cancer

Agreement

By signing my name below, I understand that a structural integration practitioner does not diagnose disease or illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that this is a professional setting. Sexual conduct is unwelcome.
Intials____

The therapist has the power to end the session for inappropriate comments or actions.
Intials____

I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the session, and they will end the session.
Intials____

I have stated all of the conditions that I am aware of, and this information is true and accurate.
Intials____

I will inform the health care provider of any changes in my health conditions, accidents, and/or surgeries.
Intials_____

Agreement: By signing below, I agree to the terms and conditions above.

Signature _____Date _____

First Name _____ Last Name _____

Consent for Therapy and Waiver of Liability

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that manual therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.

2. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that manual therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the session is completed or not.

3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist.

Agreement: By signing below, I agree to the terms and conditions above.

Signature _____ Date _____

First Name _____ Last Name _____