Collective Balance Manual Therapy Client Intake Form

Name:	Date of Birth:
Address:	City/State/Zip:
Phone:	
Occupation:	Emergency Contact:
Referred By:	Emergency #:

Have you experienced a professional massage or bodywork session? _____ Yes _____ No
How much water do you drink daily?
List activities and frequencies of sports, musical instruments, hobbies that you enjoy:
List current medications and/or supplements:
List current and previous accidents, injuries, surgeries:
List primary area of complaint:
What is your goal in seeking this type of treatment:

MUSCULO-SKELETAL
__ Neck / TMJ Pain
__ Shoulder / Arm / Hand Pain
__ Low Back / Hip Pain
__ Leg / Foot Pain
__ Osteoporosis / Arthritis
__ Spasms / Cramps
__ Numbness / Tingling
__ Bulging Disc
__ Herniated Disc
__ Spinal Stenosis
__ Spondylolisthesis
(grade level 1 2 3 4)
__ Broken / Fractured Bones
__ Hip Replacement (R / L)
__ Knee Replacement (R / L)

INFLAMMATORY
__ Acid Reflux
__ Constipation / Diarrhea
__ Irritable Bowel Syndrome
__ Depression / Anxiety
__ Sinus Condition
__ Diabetes
__ Auto Immune
__ Eczema / Psoriasis
__ Athlete's Foot

NERVOUS SYSTEM
__ Herpes / Shingles / Warts
__ Virus / Tick Borne Illness
__ Seizure Disorder
__ Fatigue / Sleep Disorder
__ Bell's Palsy / Neuropathy

CIRCULATORY SYSTEM
__ Heart Condition / Stroke
__ Varicose Veins / Blood Clots
__ High / Low Blood Pressure
__ Edema / Swelling

OTHER
__ Pregnant ____ weeks
__ Implants
__ Cancer / Tumors
__ Headaches
Type:
Frequency:
Intensity:
__ Sleeping Position:
(Back / Side / Belly)
__ Right / Left Handed

COLLECTIVE BALANCE

PLEASE READ AND SIGN:
Manual Therapy Treatment & Training sessions are designed to be a health aid and in no way are meant to take the place of a physician's care. Information exchanged during a session is educational in nature and is intended to help the client become more aware of his/her own health status and is to be used at his/her own discretion.

Because manual therapy should not be performed under certain medical conditions, I (the client) affirm that I have stated all my known medical conditions and answered all questions honestly, and I understand that it is my responsibility to keep the practitioner updated as to any changes in my medical profile.

I (the client) also understand that any illicit or sexually suggestive remarks or advances made by me toward the practitioner will result in immediate termination of the session.

LATE POLICY:
A phone call or text is appreciated should you find yourself running late. Please note that your arrival time will determine the length of the session, which will end as scheduled so as not to inconvenience the next client.

CANCELLATION POLICY:
Your treatment sessions are reserved exclusively for you. I value your business and ask that you respect the following scheduling policy. Should you need to cancel or reschedule, please notify me immediately. Cancellation with less than 48 hour notice prevents me from accommodating other clients and is subject to a cancellation fee of $135.

I recognize that there are circumstances that are out of your control. If an emergency situation arises (such as sudden illness or family emergency), please let me know so that I can treat your specific situation with personal attention.

By scheduling a session with Collective Balance and by signing below, you acknowledge the communication of this cancellation policy and fee.

PAYMENT OPTIONS:
Payment is due when services are rendered, unless other arrangements have been made prior to the appointment, and are payable via cash, check, or credit card.

Signature:	Date:

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