

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



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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