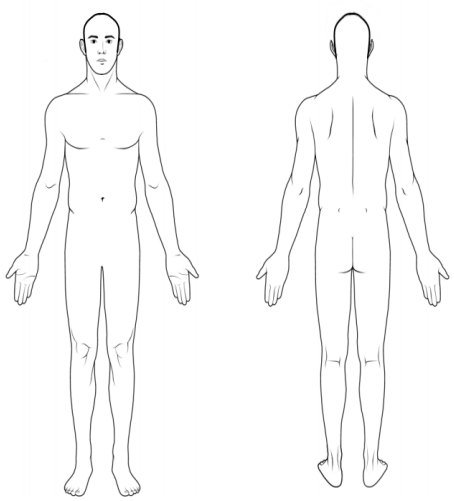
Stretch ER

New Client Intake Form

Name: _____ Date: _____
Address: _____ City, State, Zip: _____
Phone: _____ Email: _____
Birthday: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

GERNERAL INFORMATION
What specific goals would you like to achieve? _____
Where are your problematic areas located? Please mark the areas on the figures below



"

Describe the symptoms. Please check all that apply.

____ Dull	____ Ache	____ Burning	____ Sharp	____ Periodic
____ Constant	____ Sore	____ Stiff	____ Numb	____ Tingling

PHYSICAL FACTORS
What physical activities are you currently involved in? _____
How many days a week do you exercise? _____
Do you wear any type of supportive braces anywhere? If yes, where? _____

MEDICAL HISTORY
Please list any recent injuries, illness, and surgeries: _____
_____

List current medications, including aspirin, ibuprofen, etc. _____
_____

Do you have any chronic or frequent pain? _____

_____

Have you had any accidents, auto or other traumatic events? _____

_____

Have you had any major surgeries? _____

_____

Are there any other medical conditions the therapist should be aware of? _____

_____

Please check all that apply

_____ Cancer	_____ Hi/Low Blood Pressure	_____ Epilepsy
_____ Digestion Problems	_____ Elimination Problems	_____ Ulcers
_____ Immovable Joints	_____ Respiratory Problems	_____ Sinus Problems
_____ Migraines/Headaches	_____ Cold Hands/Feet	_____ Heart Problems
_____ Back Problems	_____ Neck Problems	_____ Sciatica
_____ Arthritis/Bursitis	_____ Allergies	_____ Stroke
_____ Immune Disorder	_____ Fibromyalgia	_____ Scoliosis
_____ TMJ	_____ Carpal Tunnel	_____ Osteoporosis
_____ Tendonitis	_____ Asthma	_____ Diabetes

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the therapist of my condition. I understand that this office does not diagnose of treat illness or disease and does not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment. Owner will determine emergency cancellations. It is agreed that any claim of liability is hereby waived.

Participant's Name _____

Participant's Signature _____ Date _____

Parent/Guardian of Participant of Minority Age (Under age 18 at time of registration)
This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Release from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

Parent/Guardian's_____
Parent/Guardian's Signature _____ Date _____