Client Intake / Consent Form

Name:_____ Date:_____ Gender: ❑Male ❑Female

Address:_____

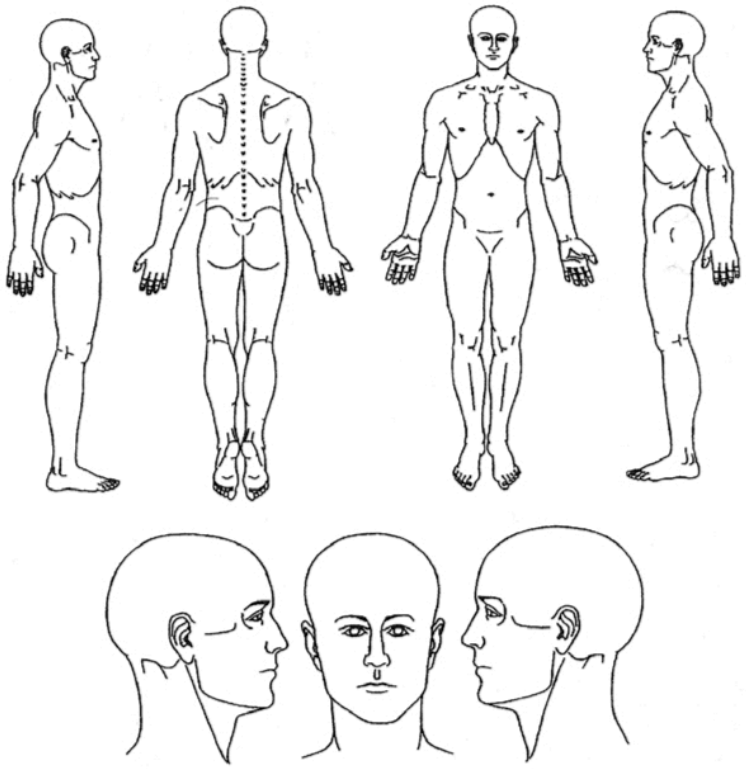
City:_____ State: _____ Zip: _____

Date of Birth:_____ Day Phone:_____ Cell Phone:_____

Email:_____ Occupation:_____

Emergency Contact: _____ Phone: _____

1. ***Indicate where you have pain or other symptoms.***



2. Describe your symptoms _____

_____

A) When did your symptoms start? _____

B) How did your symptoms begin? _____

3. How often do you experience your symptoms?

❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day)

❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

4. What describes the nature of your symptoms?

❑ Sharp ❑ Dull Ache ❑ Numb ❑ Shooting ❑ Burning ❑ Tingling

5. How are your symptoms changing?

❑ Getting Better ❑ Not Changing ❑ Getting Worse

6. During the past 4 weeks:

A) Indicate the average intensity of your symptoms. ***None*** 0 1 2 3 4 5 6 7 8 9 10 ***Unbearable***

B) How much has pain interfered with your normal work (including academics, athletics, housework, and work outside the home)?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

7. Who have you seen for your symptoms?

❑ No One ❑ Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other

*A) What is his or her name?*_____

B) What treatment did you receive and when?_____

C) What tests have you had for your symptoms and when were they performed?

❑ X-Ray *Date:*_____ ❑ MRI *Date:*_____

❑ CT Scan *Date:*_____ ❑ Other *Date:*_____

8. Have you had similar symptoms in the past? ❑ Yes ❑ No

A) If you have received treatment in the past for the same or similar symptoms, who did you see?

❑ No One ❑ Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other

9. Have you ever received advanced bodywork? (i.e. MFR, Rolfing, ART, FR, etc.)? ❑Yes ❑No

Please describe:_____

_____

10. List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

_____

_____

11. List all the surgical procedures you have had and times you have been hospitalized:

_____

_____

_____

Circulatory System
- ❑ Heart Condition
- ❑ Phlebitis / Varicose Veins
- ❑ High / Low Blood Pressure
- ❑ Swollen Ankles / Feet
- ❑ Headaches
- ❑ Other:_____

Nervous System
- ❑ Numbness / Tingling – Location _____
- ❑ Sciatica
- ❑ Pinched Nerve
- ❑ Migraines
- ❑ Other:_____

Musculoskeletal System
- ❑ Tendinosis / Tendonitis / Bursitis
- ❑ Arthritis (Osteo or Rheumatoid)
- ❑ Sprains / Strains
- ❑ Low Back / Hip/Leg Pain
- ❑ Neck / Shoulder / Arm Pain
- ❑ Spasms / Cramps
- ❑ TMJ / Jaw Pain
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Other:_____

Skin (Integumentary System)
- ❑ Allergies
- ❑ Rashes
- ❑ Athlete's Foot
- ❑ Lice / Scabies
- ❑ Other:_____

Digestive System
- ❑ Current Constipation / Diarrhea
- ❑ Gas / Bloating
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Ulcers
- ❑ Other:_____

Respiratory System
- ❑ Asthma / Breathing Difficulty
- ❑ Emphysema
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Other:_____

Other
- ❑ Diabetes
- ❑ Chronic Fatigue Syndrome
- ❑ Sleep Disorders
- ❑ Anxiety / Stress Syndrome
- ❑ Current Inflammation / Swelling
- ❑ Current Infection
- ❑ Other:_____

Client Signature:_____ Date:_____

Parent's Signature_____ *(If under 18 years of age)*

I have listed all my known medical conditions and physical limitations to the best of my knowledge. I will inform Kevin Neeld Athletic Development, LLC in writing of any change in my physical health between sessions. I understand that a massage therapist must be aware of all existing physical conditions that I have in order to provide appropriate modalities. I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have. In consideration of this, I, for myself, my heirs, and my legal representatives, do hereby release and forever discharge Kevin Neeld Athletic Development, LLC and its officers and employees from any and all causes of actions, suits, debts, claims and demands of any whatsoever arising from or by reasons of any injuries which might occur as a result of having massage therapy performed. I am responsible for rescheduling if needed and that failure to give 24 hours of notice will result in a cancellation fee of $40 on my next visit or purchased block.

I have read the above information. I understand this policy and agree to its terms.

Client Signature:_____ Date:_____

Parent's Signature_____ *(If under 18 years of age)*