Intake Form

Date:___________________

Client General Information

Name:______________________________________

Date of Birth:________________ Age:___________ Gender:__________

Address:____

Phone:_________________________Email:____

Preferred form of communication (circle one): email call text May we leave voicemail?___

Emergency contact: ___________________________ Phone:__________________________

Who is in your health care team? (ex. Chiropractors, massage therapist, general practitioner)

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Your current Occupation:____

How do you spend most of your work day? Sitting Standing Light Labor Heavy Labor

Previous occupation(s):____

Exercise habits? None Moderate Daily

Types of exercise: Running/jogging walking yoga Strength Training

High Intensity training pilates For a Sport:______________________

How much water do you drink a day on average?_____________________________________

How much coffee/caffeine drinks do you drink a day?__________________________________

On average, how much uninterrupted sleep do you get per night?_________________________

If you wake up throughout the night, what time do you typically wake up?___________________

Are you pregnant? Yes No

Do you have a pacemaker? Yes No

Recent fall? Yes No

Recent surgery? Yes No

Recent broken bone? Yes No

Do you have any known medical conditions? If so, please list below.

Do you have any joint replacements? If so, which one(s) are replaced?

Please list any injuries that may influence today's treatment:

Please list any prior hospitalizations or surgeries that may influence today's treatment:

Please list any medications that you are currently taking:

What traumas have you experienced? Child Maltreatment Community Violence

Domestic violence Medical Natural disaster School Related

Sexual War related Traumatic loss Vehicle accident None

Are there any other events that you view as traumatic or hold unresolved stress for you? Please list below.

Please fill out this page if today's treatment is for your child. Skip this page if not.

Any turamas during pregnancy? (ex. falls, accidents, death of loved one, etc.)

Any complications during pregnancy?

Did mother use drugs or alcohol during pregnancy? Yes No

How was the child born?

Vagianlly C-section Premature Induced vacuumed/foreceps

Were there any complications during or shortly after birth? (ex. Excessively long labor, cord around neck, stuck in the canal, delayed first breath, etc.)

Breastfed? Yes No If yes, for how long?________________

Difficulties with nursing/feeding?

Behavioral, learning or sensory disorders?

Hospitalizations/surgeries?

Has your child met all developmental milestones? Yes No

If no, please explain.

How did you hear about Integrate and Thrive?____

If you were referred, who referred you? (He/she will get a discount!) ______________________

Reason for seeking our techniques? What is your goal?

Have you tried any other modalities to treat the issue that you are here to get treated for? Please explain. Include the results you have had with each treatment.

Is there anything you do to try to relieve the symptoms?

Do you have any special needs that your practitioner needs to prepare for? (ex. Cannot lay on stomach)

Do you have any questions/concerns?

Integrate and Thrive Office Policies

Cancellation

A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment. Therefore, all clients will be required to have a credit card saved on file. Depending upon client history and reason for missing the appointment, the practitioner may opt to waive the cancellation fee. Please be open and honest with your practitioner. Once there is a record of 3 missed appointments without any communication, services will likely no longer be offered to this individual.

Tardiness

Appointment times are scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time for your appointment.

Sickness

Our treatment techniques are not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24 hour notice period, the cancellation fee may be waived upon approval of your practitioner.

Financial Responsibility

Appointments must be paid in full by or on day of the appointment. The previous appointment must be paid for before scheduling the next one. Ask your practitioner about which payment options are accepted. Any returned checks are subject to a fee.

Your signature below signifies acceptance of these policies*. *If the client is a minor, then the parent or guardian of the client should sign below. Please let us know if you have any questions or concerns.

Signature:____ Date:________________

Client Waiver

1) I understand that the practitioner will not workout outside his/her education and scope of practice, and he/she will be using the modality that he/she sees most fit for my condition.
2) I understand I am not receiving chiropractic, massage, physical therapy, or any other type of medical treatment.
3) If I experience pain or discomfort during the session, I will immediately inform my practitioner so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. These include but are not limited to: tenderness when touched, superficial bruising, short-term muscle soreness, detoxification symptoms.
4) When applicable, I have received permission from my physician to resume normal activity.
5) I understand that the services offered today are not a substitute for medical care. I understand that my practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
6) I affirm that I have notified my practitioner of all known medical conditions and injuries. I agree to inform the practitioner of any changes in my health and medical condition. I understand that there shall be no liability on the practitioner's part should I forget to do so.
7) I understand that my practitioner will be touching me and that bodywork is entirely therapeutic and non-sexual in nature.
8) I understand that I or the practitioner can terminate the session at any time.
9) By signing this release, I hereby waive and release my practitioner from any and all liability, past, present, and future relating to the modalities used.
10) I have been given a chance to ask questions about the session and my questions were answered.
11) I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment without an agreed upon emergency, I am subject to a fee equal to the cost of the missed appointment. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.
12) Client agrees that a signed digitized form of this paper will constitute as the original document.

Name:____ Date:___________________

Treatment of Minor

I, _____________________, being the parent or legal guardian of __________________,Have read and fully understand the above terms of acceptance and herby grant permission for my child to receive treatment. For future visits I authorize my minor child to receive treatment without my presence if applicable. Signature:_______________________________________

Relation to child:___________________________ Date:____________________