CLIENT INTAKE FORM

Date: ______________________ Name: ______________________________ DOB: __________ Sex: ______
mm/dd/yy mm/dd/yy

Address: ____ City: ______________________

Postal Code: ______________________ Email Address: __________________@__________

Cell: (   ) ______________________ Emergency Contact Name: ______________________________

Home: (   ) ______________________ Emergency Contact Phone: (   ) ______________________

Work: (   ) ______________________ May I call you at work? Yes _____ No _____

Referred by: ______________________ ____________

Therapy can be administered:

Fully clothed: [ ] Primary Physician Name: ______________________________

Loose cloths (i.e. shorts and t-shirt): [ ] Physician Phone: (   ) ______________________

Bra and underware: [ ] Specialist Name: ______________________________

No preference: [ ] Specialist Phone: (   ) ______________________

State your preference: ____________________________________

Primary complaint/reason for seeking treatment: ____

____

Pain location: ____

Intensity of pain: (Scale of 1 - 10) ____________ see below

Pain scale described as:

(2) Mild pain, annoying, nagging

(4) Discomforting, troublesome, numbing

(6) Distressing, miserable, agonizing

(8) Intense, cramping, dreadful, horrible

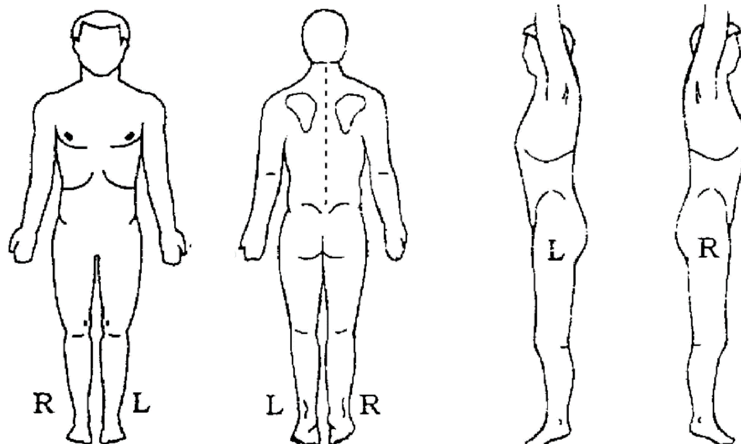
(10) Excruciating, tearing, crushing, unbearable

When does your pain increase?: ____

When does your pain decrease?: ____

Please indicate by circling location of your pain or condition

Pain patterns/restricted movements:



What medications are you currently taking?:

____

____

____

List of surgeries and dates:

____

____

List previous injuries and dates:

____

____

____

____

____

What kind of physical activities do you do and how often?

____

____

Do you smoke?: ________________ How much?: ________________ How long?: ________

Do you wear orthotics? _______________ How long have you had this current pair?: ______________________

Have you received any other type of body work on the past 5 days? Yes _____ No ______

What type of work did you have?: ____

What other types of body work have you had in the past?: ______________________________

____

Please identify any implants, internal pins, wires, artificial joints or special equipment you may have:

____

____

Please identify and explain any health conditions you are experiencing or have a history of.

o Bronchitis/asthma/shortness of breath or chronic cough

____

____

o Poor circulation/bruise easily

____

____

o Loss of sensation in hands or feet

____

____

o Pregnant: Yes___ No ___

Due date: ______________________________

Are you trying to conceive? Yes ____ No _____

How long have you been trying? __________________

Indicate your own birth history if known: i.e. c section, forceps, breech birth, premature

____

o PMS, fibroids/difficult menstruation: ____

o Last menstrual period: ____

o Liver/gallbladder/poor digestion: ____

____

o Insomnia: ____

o Hiatus hernia: ____

o Constipation/diarrhea - please indicate number of BM's per day or per week ______________________

o Numbness/tingling: ____

o Diabetes: Yes___ No___

Type: ____

Date of Onset: ____

o Allergies: (type, severity, symptoms) ____

____

o Hayfever: ____

o Epilepsy: ____

o Cancer: ____

o Arthritis: ____

o Vision issues: ____

o Ear infections/poor hearing/tinnitus: ____

o Bladder/kidney: ____

o Joint or soft tissue pain: ____

____

o High or low blood pressure: ____

____

o Heart attack(s) and date (s): ____

o Congestive heart failure, heart disease, stroke: ____

o Phlebitis: ____

o Pacemaker: ____

o Headaches (frequency and triggers): ____________________

____

o Hepatitis, TB: ____________________

o Skin rashes/infectious skin conditions: ____________________

o Fibromyalgia: ____________________

o Back pain: ____________________

o Varicose veins: ____________________

o Psychological issues/traumas: ____________________

____

____

o Other: ____________________

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____

I, (print)____ understand the treatment goals, risks and benefits as explained by Carol Roddy and I give consent to treatment. I have had an opportunity to ask questions about the treatment. I understand that Carol Roddy does not treat, prescribe or diagnose any illness, disease, or other physical or mental disorder and that any information concerning health status relayed to Carol Roddy has also been given to my physician. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby give Carol Roddy permission to collect personal information, including personal health information from me and from the facilities and persons listed and to release such information to the following facilities and/or persons for the purpose of providing services to me and for the purpose of information sharing in support of care planning and service provision. These facilities/persons include the clients' health care team i.e. physician, pharmacist, naturopath, RMT, chiropractor or other regulated health care provider. I understand that the client may request access to their personal information at any time and may revoke or amend this authorization in writing at any time. Upon completion of my treatment program, any request for Carol Roddy to share/release client specific information acquired through the episode of care will require a specific informed consent from the client for release of specifically requested information.

Signature ____ Date _______________________________