CLIENT INTAKE FORM

PERSONAL INFORMATION

Name Date

Phone E-mail

Address

City State Zip Code

Birth Date Occupation

Emergency Contact Relationship

How did you hear about AC MFR?

HEALTH INFORMATION

1. What is the primary complaint that brings you here?

2. Please list any secondary complaints you would like to address.

3. How and when did your symptoms begin?

4. Have you ever received other treatments for this condition?

5. What are your goals for therapy?

6. Please list any surgeries, accidents or traumas (physical or emotional) and the dates of occurrence.

7. Please list all medications that you are currently taking, the reason for which you are taking them.

8. Please check any of the conditions that you have or have had in had in the past. Mark with a "c" if current and with a "p" if in the past.

MAJOR MEDICAL
Heart Disease
Cancer
High/Low Blood Pressure
Diabetes
Stroke/CVA
Epilepsy/Seizures
Lung Disease
Aneurysm

CIRCULATORY
Hypertension
Edema
Reynaud's Disease
Varicose Veins
Heart Attack
Cardiovascular Disease
Blood Clots
Bleeding Disorder
Diabetes (Type 1 or 2)

DIGESTIVE
Ulcers
Colitis
Gallstones
Hepatitis/Liver Disease
Constipation
Diarrhea
Gas/Bloating
Indigestion/Heartburn
IBS/Crohn's Disease

NERVOUS SYSTEM
Shingles
Multiple Sclerosis
Parkinson's Disease
Bell's Palsy
Spinal Cord Injury
Seizure Disorders
Numbness/Tingling

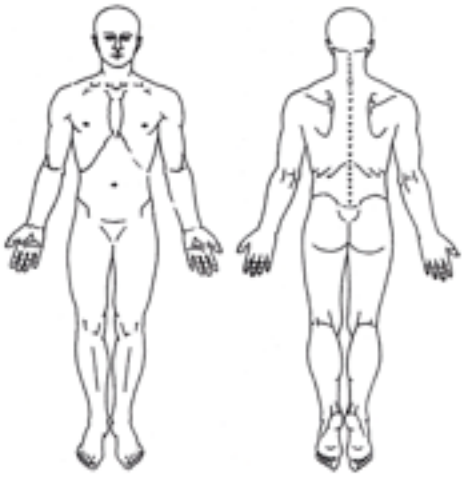
RESPIRATORY
Pneumonia
Sinus Problems
Allergies
Asthma

SKIN
Fungal Infections
Impetigo
Dermatitis/Eczema
Psoriasis
Cosmetic Surgery

OTHER
Osteoporosis
Hernia
Difficulty Sleeping
Tinnitus
Sleep Apnea
Dizziness/Vertigo
Anxiety/Panic Attacks
Depression
Thyroid Condition
HIV

CLIENT INTAKE DIAGRAM

Please identify areas of soreness or pain with a (P), numbness (N), weakness (W), and scars (S).



CONSENT TO TREAT

I give Adrienne Corna MFR permission to provide treatment that will include MFR, manual therapy and therapeutic exercise. I understand that in order for me to fully benefit from the treatment provided, I will have to participate in self treatment outside of my treatment sessions to progress my healing process.

In order for my therapist to most effectively treat me with manual therapy, I may be asked to remove some clothing during treatment. If I am uncomfortable with this, I will share my concerns with my therapist and they will abide by my request. I acknowledge that Adrienne Corna MFR must be fully aware of my existing medical conditions. I have completed the client intake form and have disclosed, to the best of my knowledge, all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I understand that draping will be used during treatment unless otherwise agreed to by my therapist and me. My therapist will not perform breast massage on female clients without prior written consent.

I understand that appointment times are held specifically for me. I am committed to my treatment and will show up for my scheduled time. If I need to change my appointment I will notify Adrienne Corna MFR within 24 hours or I will responsible for full payment of my treatment.

I have read the above noted consent. By signing this form, I consent to treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client signature_____ Date_____

Therapist Signature _____ Date _____