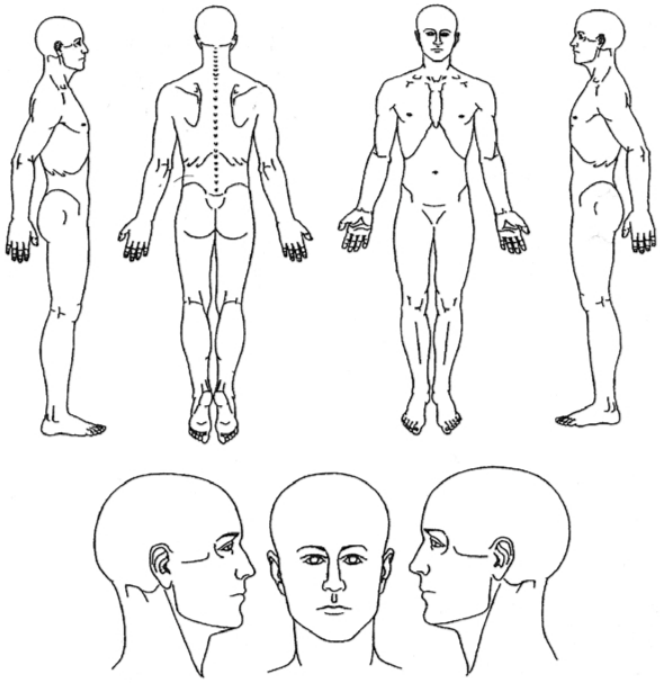
Client Intake & Consent Form

Name _____ Date: _____ Gender: __ Male __ Female
Street Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Best contact number or Cell Phone: _____
Email: _____ Occupation: _____
Emergency Contact: _____Phone: _____ (must be different than your numbers)

What are your goals for this therapy? _____

1. Indicate where you have complaints, pain or other symptoms



2. Describe your symptoms/complaints _____ _____
_____

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:

None Unbearable

A) Indicate the average intensity of your symptoms. 0 1 2 3 4 5 6 7 8 9 10

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 their 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 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 received FST or other types of bodywork before? __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 the times you have been hospitalized:

_____

_____

12. Please describe you sleeping patterns- please as descriptive as possible☺

How many hours do you regularly get per night? _____

Do you wake up during the night? _____

Do you have trouble falling to sleep? _____

If so why _____

If so when_____

Do you dream? _____

13. Is there any other info you wish to provide to aid in the success of your care? _____

_____

Client Consent for Treatment

Please read carefully and sign below

By signing this consent, I agree that I have stated all conditions that I am aware of and the information is true and accurate to the best of my knowledge. I will inform my health care provider, or practitioner if anything changes in my status. I understand that bodywork I receive is for the purpose of increased flexibility, stress reduction and relief from muscular tension, spasm or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform my practitioner so that the intensity and/or methods can be adjusted to my comfort level. I understand that utilization of this type of modality can possibly increase soreness and/or pain if I do not communicate honestly and or follow proper precautions following the session. I understand that information exchanged during any session is educational in nature and is intended to help the client become more familiar and conscious of his or her own health status.

I understand that an FST Practitioner cannot diagnose illness, disease, or any physical or mental disorders. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal or skeletal manipulations. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis, and I understand that it is my responsibility to consult a physician for any ailments I may have.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I understand that I am choosing Frederick Stretch Therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid therapy I hereby hold harmless and release from any liability as well as any officers, directors, or employees of for any condition or result, known or unknown that may arise as a consequence of any treatment I receive. Sexual advances and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated, resulting in the immediate termination of the session and I will be liable for payment of the scheduled treatment.

I agree to abide by a 24 hours cancellation notice for any scheduled appointment. I understand I may be charged up to the full amount of the service for missed appointments or for any cancellations with less than a 24-hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the practitioner is late, they will fulfill the scheduled appointment length or offer a reasonable compensation.

Client Signature: _____ Date: _____

Parent's Signature: _____ (If under 18 years of age)