RELEASE + RESTORE

Intake Form

Name: _____ Date: ____/____/ _____

Gender: _____ Male _____ Female Age: _____ Date of Birth: ____/ ____/ _____

Home phone: (_____) _____ Work phone: (____)_____Ext._____

Mobile phone: (_____)_____ Email: _____

Home address: _____

City: _____State: _____ Zip Code: _____

Emergency contact: _____Phone:_____Relationship:_____

How did you hear about us? [Check all that apply]

- ☐ Word of Mouth
- ☐ Website
- ☐ Online Article
- ☐ Talk/Presentation
- ☐ Online Ad
- ☐ Printed Ad
- ☐ Brochure
- ☐ Television
- ☐ Social Media/Youtube
- ☐ Health Care Referral (Name of Physician):_____
- ☐ Other (Please Specify):_____

In which areas are you looking for improvement? [Check all that apply]

- ☐ Posture Improvement
- ☐ Lower Back Pain
- ☐ Upper Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Tension
- ☐ Other (Please Specify):_____

Lifestyle

Job Title (If retired, please state "Retired" and employment history):

_____

How many hours/day do you work? _____ How many days/week do you work? _____

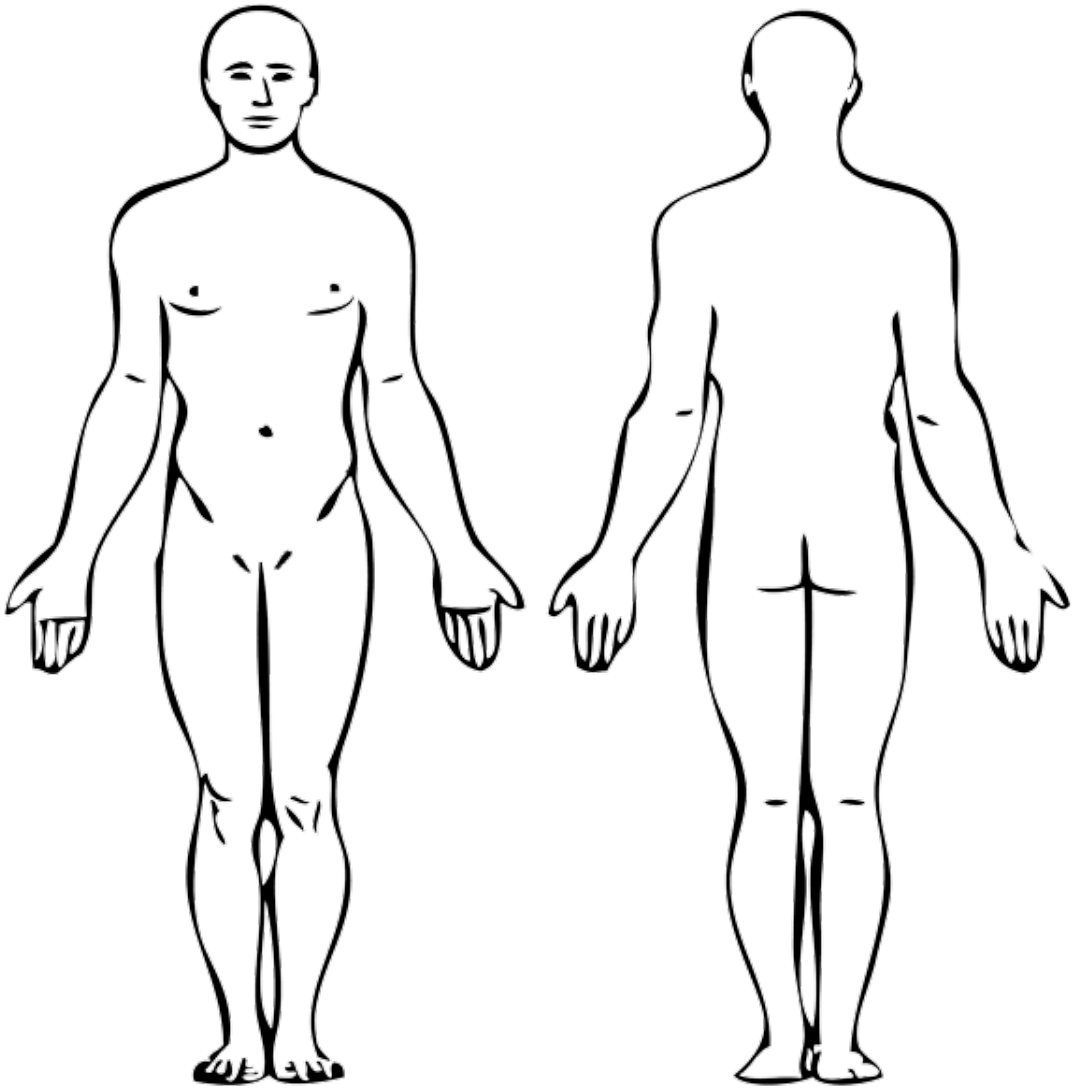
Please describe your job routine (example: I do professional work and deal with the public. I sit at a desk most of the day and use a computer and phones most of the time. I drive to work and commute about 45 minutes each way.)

_____

_____

_____

✕ Mark Areas of Pain/Tension



Have you ever been diagnosed with a herniated disc? If so at what level/s? And is this a current condition?

_____

What treatments have you received? _____

_____

_____

Were they helpful? _____

Medications you are currently taking:_____

Do any of the following affect your symptoms? (Mark : ☑ For Improves ☒ For Worsens)

☐ Heat ☐ Cold ☐ Pressure ☐ Work ☐ Rest

☐ Medication ☐ Morning ☐ Afternoon ☐ Evening ☐ Exercise

Health History

Please write a short account stating your history of pain and injuries, in chronological order.

(Example: Age 10: skiing accident, broke L2-L3, resolved with fusion surgery. 2007: C5-C6 herniation...)

_____

_____

_____

List any surgery you have had and the year it was performed:

_____

_____

List of current musculoskeletal conditions and diagnoses (Please list all muscle and joint pain, injuries and diagnoses, e.g. bulging L5-S1 disc, stenosis) _____

_____

Major illnesses: _____

How would you describe your pain? (Sharp, dull, stabbing, throbbing, etc.)_____

Rate your pain on a scale of 0-10 (0 = no pain, 10 = worst pain you've had related to your symptom) _____

General Health

Sleep pattern: How many hours per night do you usually sleep? What time do you usually go to bed? What time do you usually get up? _____

_____

Is your sleep interrupted (child needs, bathroom, pain...)? How long does it take you to go back to sleep? Do you feel rejuvenated by your sleep or do you wake up tired? _____

_____

Do you have diarrhea, constipation, irritable bowel syndrome or other digestive difficulty? _____

Do you keep a specific dietary regimen? (Vegetarian, diabetic, etc.) _____

Do you have any allergies? _____

Are you currently pregnant? ☐ Yes ☐ No

Have you had a C-Section previously? ☐ Yes ☐ No

Recreation

Exercise routine (please list frequency):

_____

Hobbies:

_____

How many hours/week do you spend on your hobbies?

_____

What do you do to relax?

_____

What type of music relaxes you?

_____

Main Goals/Comments:

_____

_____

_____

_____

_____

_____

_____

Email Newsletter

May we add you to our email newsletter? ☐ Yes, please. ☐ No thank you.

Thank you very much for completing this form!
Please bring it to your first session.
Contact me if you have any questions!

Warmly,

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