Intake Form

Date

Client Name | Date of Birth

Email Address

Street | City | State | Zip

Phone (Mobile) | Phone (Home)

Emergency Contact | Phone

If patient of upper cervical chiropractic, how long?

Who referred you?

Personal Health

Activity level (please select)	Height
[ ] **Very Light:** Stay at home/no activity	Weight
[ ] **Light**: Office activity	Blood Pressure
[ ] **Moderate:** Walk 20 minutes/day	Occupation
[ ] **Sport:** More than 2 hours/week	Blood Type (Please circle) O A B AB

Cardiovascular Health: (check all that applies)

[ ] Chest Pain	[ ] Heart Attack
[ ] Blood Clots	[ ] Tachycardia
[ ] Varicose Veins	[ ] Atrial Fibrillation
[ ] Premature Ventricular Contractions PVC	[ ] Stroke

Any other heart conditions:

Skeletal Health: (check all that applies)

[ ] Arthritis	[ ] Scoliosis
[ ] Bursitis	[ ] Back Pain
[ ] Broken Bones	[ ] Neck Pain
[ ] Bulging/Herniated Disks	[ ] Sciatica
[ ] Sprained Ankles	

Any other skeletal conditions

Oral Health: (check all that applies)

[ ] Crowns How many times?	[ ] Wisdom Teeth yes no
[ ] Root Canals	[ ] Tonsillectomy yes no What age?
[ ] Bridges	
[ ] Implants	[ ] Bite Guard How old?
[ ] Orthodontics What age? How many times?	[ ] Temporomandibular Disorders

Women's Health	Men's Health
Are you pregnant? Weeks?	[ ]Prostatitis [ ]Vasectomy
How many births have you had? Type of birth?	[ ]Erectile Dysfunction [ ]Low Testosterone
Do you know about your birth? Please give any details	Do you know about your birth? Please give any details
[ ]Menstrual Pain/PMS [ ] Hysterotomy	
[ ]Endometriosis [ ] PCOS	

Other (check all that applies)

[ ] Tinnitus	[ ] Sleep Apnea
[ ] Dizziness	[ ] Abdominal Hernia Mesh?
[ ] Numbness	[ ] Edema/Swelling
[ ] Sinusitis	[ ] Diabetes [ ]Type I [ ]Type II
[ ] Thyroid Problems	[ ] Skin Disorders
[ ] Substance Abuse	[ ] Corrective Lenses
[ ] Severe Depression Medicated?	[ ] Other Issues Related to Eyes
[ ] Anxiety Medicated?	
[ ] Vertigo	

Cancer? Please Explain

Digestive problems? Diarrhea? Constipation?

Migraines/headaches?

Head Trauma? Concussions? Whiplash?

Nose/Nasal injuries?

Respiratory Issues?

Have you had any surgeries? Please explain

Do you have any health conditions not listed above?

Allergies? Please explain

List food allergies

Are you under the care of another Health Care Practitioner? Yes No

What kind?

Reason

Please list any medications and what they're for

Anything else you'd like us to know

I_____

voluntarily request to receive services from Elements of Healing LLC. These services may include Craniosacral Therapy, Raindrop Therapy, Relaxation Massage and Medical Massage. I agree that the information above is acuate and have
I acknowledge that the services above are meant to support and aid in my choice to bring balance and wellness to my life.
By signing below, I understand the following:

1. **Nature of Treatment:** The treatment may involve physical manipulation, pressure, gentle touch, mouth work techniques, use of essential oils, hot compress if I should so choose.
2. **Possible Risks:** I understand there may be mild discomfort or soreness following treatment.
3. **Confidentiality:** My personal and health information will remain confidential.
4. **Voluntary Participation:** I acknowledge that I can stop the treatment at any time

I agree to inform the practitioner of any changes to my health and medical conditions and that there shall be no liability on the practitioner's part should I forget to do so.
By signing this release, I waive and release Elements of Healing from any liability, past, present, and future, relating to body work and massage therapy.

Cancelation Policy:

I will provide 24hr notice to cancel my appointment. Any cancelation made within 24hr of my appointment time will be charged 50% of the appointment fee which will be due prior to being seen for my next appointment

I understand that I am responsible for payment on the day the service is rendered. Please initial: _____

Clients name_____ Parent/Guardian's Name_____

Client's signature or Parent/Guardian Signature_____ Date_____