by wave clinic waveform therapy

Joint Pain & Mobility Intake Form

Name: _____ Date of Birth: _____

Phone: _____ E-mail:_____

Occupation: _____

Emergency Contact: _____Phone: _____

Are you currently under a physicians care for an acute or chronic illness? Y __ N __

If yes, please explain: _____

Your health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? Y __ N __

If yes, please list: _____

Have you tried other therapies and/or treatments for your condition? Y __ N __

If yes, please list: _____

What are you currently experiencing that you would like addressed? Please explain: _____

_____

How long have you been experiencing these symptoms? _____

_____

How did you hear about us? _____

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions

__ Abdominal /digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or a lung condition
__ Athletes foot
__ Blood clots
__ Chronic pain
__ Circulatory/heart problems
__ Constipation/diarrhea
__ Depression
__ Diabetes
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ High blood pressure
__ Jaw pain/TMJ pain
__ Low blood pressure
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pregnancy
__ Rash/fungus
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Vision problems
__ Varicose veins
__ Other _____

Elaborate on noted areas above: _____

_____

Please list any injuries or surgeries in the last 5 years: _____

_____

Please list your stress-reduction activities, hobbies, exercise and frequency:_____

_____

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving massage 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 massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: _____ Date: _____