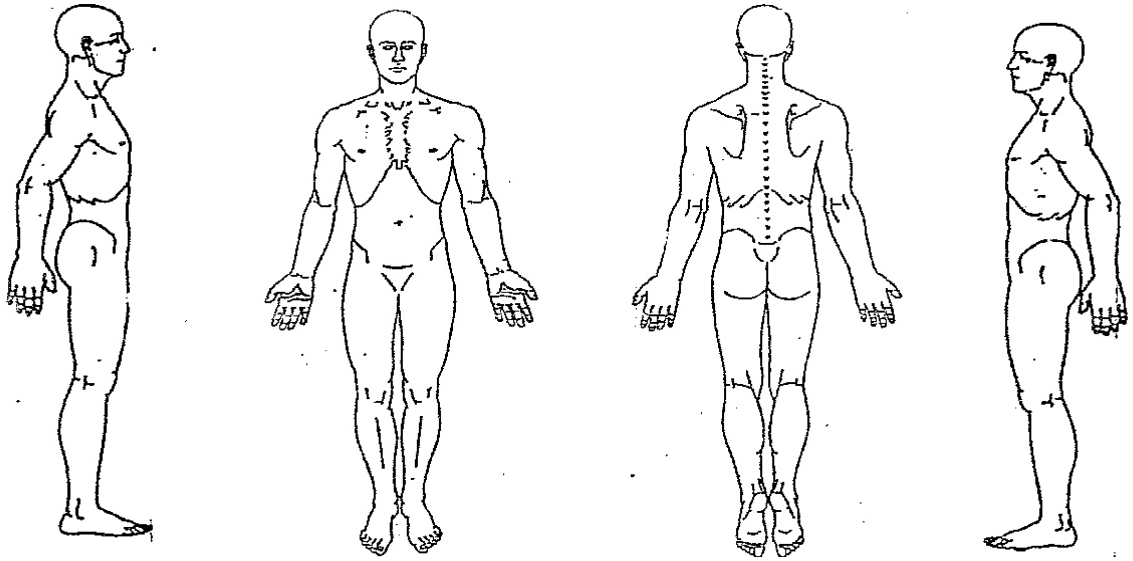
BOULDER BODYWORKS

Client Intake Paperwork

Today's Date:	How did you hear about us?		
First Name:	Date of Birth:	Height:	
Last Name:	Gender:	Weight:	
Nickname:	Occupation:		
Email:	Emergency Contact Information		
Mobile Number:	Name:		
Mobile Network Provider:	Relationship:		
Home Number:	Phone #:		
Work Number:	Email:		
☐ Check this box if you DO NOT want to receive texts from us.			
For appointment reminders & notifications, how do you prefer to be contacted? (check all that apply)	☐ Text	☐ Email	☐ Both
Address:	City:	State:	
Zip:	Country:		
Females: Are you pregnant? Y / N	High Risk? Y / N	How many weeks?	Due Date:
Presenting Complaints:			
Goals for treatment:			

Please **circle areas of pain**, mark **P for "pins & needles"** and **N for "numbness".**



List all surgeries and approximate dates (include cosmetic surgeries):

List all motor vehicle and other types of accidents (include approximate dates):

List all fractured bones, sprains and major falls:

Do you remember any falls on your tailbone? (Think of episodes on snow or ice):

List any concussions, head injuries, and brain injuries:

List previous medical diagnostic tests and finds (blood chemistry, MRI, etc.) pertinent to presenting complaint(s):

List any major illnesses or recurrent illnesses (i.e. Mono. etc.):

List previous treatments for presenting complaint(s) and results:

List all medications/nutritional supplements you take (include brand name & dosage):

Please describe your current activities:

List any other information you would like to include:

Medical History

Please mark all that apply with an X.

Health History
___ Alcoholism
___Allergies/Hayfever
___Alzheimer's disease
___ Arthritis
___Asthma
___Autoimmune disease
___High blood pressure
___Low blood pressure
___Bronchitis
___Cancer
___Carpal Tunnel
___Chronic Fatigue
___Chronic infections
___Circulatory problems
___Colitis
___Dental problems
___Depression
___Diabetes
___Diverticulitis
___Drug addiction
___Ear, nose, throat problems
___Eating disorder
___Elevated Cholesterol
___Emphysema
___Environmental sensitivities
___Epilepsy
___Fibromyalgia
___Food intolerance
___Gastroesophageal reflux
___Genetic disorder
___Glaucoma
___Gout
___Heart disease
___Kidney disease
___Learning disabilities
___Liver/gall bladder disease
___Mental illness
___Migraine headaches
___Neurologic disease
___Obesity
___Osteoporosis
___Pneumonia
___Sexually transmitted disease
___Sinus problems
___Skin problems
___Stroke
___Thyroid dysfunction
___Tuberculosis
___Ulcer
___Urinary tract infection
___Varicose veins
___Other_____
___Other_____
___Other_____

Family Health History
___Alcoholism
___Alzheimer's disease
___Arthritis, rheumatoid
___Arthritis, osteoarthritis
___Cancer
___Depression
___Diabetes
___Drug addiction
___Eating disorders
___Genetic disorders
___Glaucoma
___Heart disease
___Infertility
___Mental illness
___Migraine headaches
___Neurologic disorder
___Obesity
___Osteoporosis
___Stroke
___Suicide
___Other_____

Female Health
___Breast cancer
___Diminished sex drive
___Endometriosis
___Infertility
___Fibrocystic breasts
___Menstrual Irregularities
___Ovarian Cysts
___Pelvic inflammatory disease
___PMS
___Uteran fibroids
___Vaginal infections
___C-section
___Hysterectomy
___Menopause
___Recent changes in menstrual flow?
Age of 1st period_____
Date of last period_____
Date of last GYN exam_____
Mammogram +___ -___
Pap +___ -___
Form of birth control_____
# of children_____
# of pregnancies_____

Male Health
___Benign prostate hyperplasia
___Diminished sex drive
___Infertility
___Prostate cancer
___Other_____

Your primary treatment goals are
___Allergy relief
___General wellness
___Headache relief
___Increased sex drive
___Increased strength
___Improved brain function
___Improved digestion
___Improved moods
___Improved range of motion
___Improved skin, hair, nails
___Improved sleep
___Lower risk of disease
___More energy
___Pain relief
___Other_____
___Other_____
___Other_____

Consumption Habits
___Smoke
cigarettes per day_____
___Alcohol
Wine: glasses per day/wk___
Beer: # per day/wk_____
Liquor: oz. per day/wk_____
___Caffeine
Coffee: #6oz cups/day___
Espresso: #oz/day_____
Tea: #6oz cups/day_____
Soda: #cans/day_____
_____Water
# of glasses/day_____

Exercise
___1–2 days/wk
___3–4 days/wk
___5-7 days/wk
___45+ min/workout
___30-45min/workout
___<30min/workout
___Walk
___Run, jog, jump rope
___Weight lifting
___Swim
___Martial arts
___Yoga
___Pilates
___Tai Chi
___Cycling
___Other_____
___Other_____

Diet
___Omnivore (meat & vegetables)
___Vegetarian (vegetarian + milk/eggs)
___Vegan (vegetarian & NO eggs/milk)
___Salt restriction
___Fat restriction
___High Carbohydrate diet
___Calorie restriction

Known Food Sensitivities
___Dairy
___Wheat
___Eggs
___Citrus
___Soy
___Corn
___Nuts
___Other_____
___Other_____
___Other_____

Food Frequency
*** servings per day
___Cooked grains
___Fruit
___Vegetables
___Beans
___Dairy
___Eggs
___Meat, poultry, fish
___Water

Eating Habits
___Three meals/day
___Two meals/day
___One meal/day
___Graze (small frequent meals)
___Food rotation
___Eat constantly whether hungry or not
___Generally, eat on the run
___Add salt to food

Do you consider yourself
___Underweight
___Ideal weight
___Overweight
___Unintentional weight loss/gain lately
___Other

Sleep Habits
___Sleep well-no problems
___Sleep disturbance-mild
___Sleep disturbance-moderate
___Sleep disturbance-extreme
___Sleep apnea
___Awaken to urinate
___Recent changes in sleep
___Use medication to sleep
___Awaken same time each night at_____a.m./p.m.
Generally sleep_____hrs/night

Do you wear
___Corrective lenses
___Dental appliances
___Dentures
___Hearing aids
___Orthodontics

Is your job associated with
___Extensive stress
___Harmful chemicals
___Repetitive movement
___Heavy lifting
___Life threatening activities (e.g. firefighter)

Do you experience any of these general symptoms daily?
___Bleeding
___Constipation
___Chronic pain/inflammation
___Depression
___Diarrhea
___Disinterest in eating
___Disinterest in sex
___Dizziness
___Fatigue
___Fecal incontinence
___Headaches
___Insomnia
___Itching/Rash
___Low grade fever
___Mucous or pus discharge
___Nausea
___Panic attacks
___Shortness or breath
___Urinary incontinence
___Vomiting

Cancellation Policy

BoulderBodyworks requires a full **24 hours' notice** for any cancellations, schedule changes or 'no-shows'. You will be charged the full fee if you miss or change your scheduled appointment with less than 24 hours' notice.

BoulderBodyworks does not have administrative support on **Saturdays or Sundays**. Any cancellations or schedule changes for **Monday** must be completed by **NOON** on the **previous Friday**. Any changes made later than noon on Friday will be subject to charge.

By signing this cancellation policy:

I _____ (print your name) agree to pay all charges that are a direct result of my missing or canceling an appointment without appropriate notice. I understand that the credit card on file will be charged for the full amount no earlier than 48-hours after my missed or late cancelled appointment. If I would like to use a different method of payment, I understand that it is my responsibility to contact *BoulderBodyworks* prior to the 48-hour time frame to provide my preferred method of payment.

Signature: _____ Date: _____

Waitlist Policy

The waitlist policy applies to all classes and appointments except for Comprehensive Manual Therapy with David Schwartz and Orthopedic Manual Therapy with Elizabeth McClain.

If an appointment or space in class becomes available with greater than 24 hours' notice in accordance with your waitlist request, the appointment or class will automatically be booked and you will receive a confirmation of the booking. The cancellation policy will apply to that booking.

If an appointment becomes available with less than 24 hours' notice or after 12pm on a Friday for a Monday, *BBW* will contact all clients on the waitlist with the opening. The first to confirm will be scheduled.

Should you no longer be available for an appointment or class that you requested, it is your responsibility to cancel the reservation in accordance with the cancellation policy.

On-Time Policy for Traditional Osteopathic Manual Therapy

We know that your time is valuable. As such, we do our best to maintain a punctual schedule. Please be aware, the practices of Comprehensive and Orthopedic Manual Therapies are not a linear, therefore a practitioner may run late. We ask you to be on time for your scheduled appointment, but we also ask for your patience when a practitioner is running behind.

We do our best to call ahead and give you advanced notice if we know a practitioner will be 15 minutes or more behind schedule, but this is not always possible. We strongly recommend that you do not schedule other appointments immediately following your appointment as we will not issue a partial or total refund if you cannot stay for the completion of your appointment. Please sign below to indicate that you have read and understand this policy.

Signature: _____ Date: _____

Cancellation List Policy for Comprehensive Manual Therapy with David Schwartz & Orthopedic Manual Therapy with Elizabeth McClain

Should you be added to the cancellation list, please ensure you give us the best number at which to reach you and inform us of preferred and unavailable dates. Openings are entirely dependent on whether another client cancels an appointment. Should we contact you, please respond as soon as possible. *BoulderBodyworks* will call everyone on the cancellation list for each available appointment. The first person to answer or respond will be booked.

Signature: _____ Date: _____