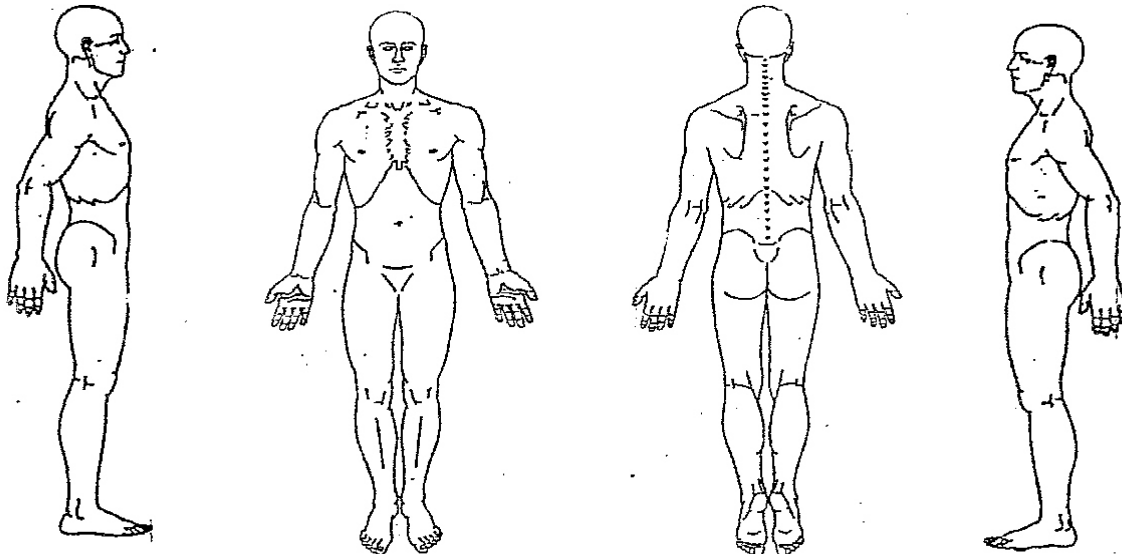


## Client Intake Paperwork

Today's Date:		How did you hear about us?			
First Name:		Date of Birth:	Height:		
Last Name:		Gender:	Weight:		
Nickname:		Occupation:			
Email:		<u>Emergency Contact Information</u>			
Mobile Number:		Name:			
Mobile Network Provider:		Relationship:			
Home Number:		Phone #:			
Work Number:		Email:			
<input type="checkbox"/> 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)			<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> 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):

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---

---

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

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---

List all fractured bones, sprains and major falls:

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---

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

---

---

---

List any concussions, head injuries, and brain injuries:

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---

---

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

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---

---

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 1<sup>st</sup> 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

For **Monday** appointments or class reservations, we require that you notify us by **12PM** on the **previous Friday** to make any changes or cancellations. Changes made later than **12pm** on the previous Friday for a Monday appointment will be subject to the full fee of the service you were booked for. \_\_\_\_\_ Initial

For **Tuesday-Saturday** appointments and class reservations, we require a full **24 hours' notice** for any cancellations or schedule changes. You will be charged the full fee if you miss, cancel or change your scheduled appointment with less than 24 hours' notice for Tuesday-Saturday appointments. \_\_\_\_\_ Initial

We are closed on the following **Holidays**: New Years, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas. If you are scheduled to come in the day after one of these holidays, we require that you notify us by **12PM** the **previous business day** to cancel or make any schedule changes. Changes made later than **12PM** the **previous business day** for an appointment scheduled after a Holiday will be subject to the full fee of service you were booked for. \_\_\_\_\_ Initial

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 for Pilates Classes

If you are waitlisted for a class and a space in the class becomes available with greater than **24 hours' notice**, you will automatically be scheduled into the class and you will receive a confirmation of the reservation. The cancellation policy will apply to the class reservation.

If you are waitlisted for a class and a space in the class becomes available with less than **24 hours' notice** or after **12pm** on a Friday for the following Monday class, we will contact all clients on the waitlist with the opening. The first to confirm will be scheduled.

Should you no longer be available for the class that you are waitlisted for, it is your responsibility to either remove yourself from the waitlist or to ask us to remove you from the waitlist. If you are on the waitlist and get put into a class and you do not show up for the class or cancel out of the class outside of the cancel policy deadline, you will be charged for the price of the class. \_\_\_\_\_ Initial



**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: \_\_\_\_\_