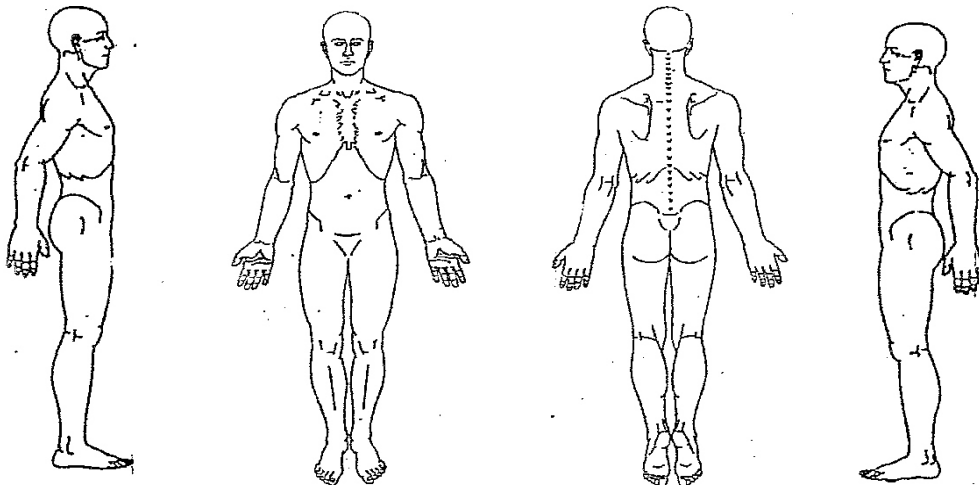




Client Intake Paperwork

Today's Date:		How did you hear about us?				
First Name:		Date of Birth:		Height:		
Last Name:		Gender:		Weight:		
Nickname:		Pronouns:		Occupation:		
<u>Contact Information</u>			<u>Emergency Contact Information</u>			
Email:			Name:			
Mobile Number:			Relationship:			
Mobile Network Provider:			Mobile Number:			
Home Number:			Work Number:			
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:				
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 for current and a P for past.

General Health History

- ☐ Allergies/Hay fever
- ☐ Alzheimer's/dementia
- ☐ Anxiety disorder
- ☐ 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
- ☐ 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
- ☐ Lyme disease
- ☐ Mental health condition
- ☐ Migraine headaches
- ☐ Neurologic disorder
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sinus problems
- ☐ Skin problems

- ☐ Stroke
- ☐ Substance use disorder
- ☐ Thyroid dysfunction
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose veins
- ☐ Other _____
- ☐ Other _____

Family Health History

- ☐ Alzheimer's/dementia
- ☐ Anxiety disorders
- ☐ Arthritis, rheumatoid
- ☐ Arthritis, osteoarthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Genetic disorders
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Mental health conditions
- ☐ Migraine headaches
- ☐ Neurologic disorder
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance use disorders
- ☐ Suicide
- ☐ Other _____

Reproductive Health History

- ☐ Benign prostate hyperplasia
- ☐ Diminished sex drive
- ☐ Infertility
- ☐ Prostate Cancer
- ☐ Sexually transmitted infection
- ☐ Urinary Tract infection
- ☐ Breast Cancer
- ☐ Endometriosis
- ☐ Fibrocystic breasts
- ☐ Menstrual Irregularities
- ☐ Ovarian Cysts
- ☐ Pelvic inflammatory disease

- ☐ PMS
- ☐ Uterine fibroids
- ☐ Vaginal infections
- ☐ C-section
- ☐ Hysterectomy
- ☐ Hormone replacement
- ☐ 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 _____
- Other _____
- 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 _____

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
___ Prosthetics

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
___ Other _____



Regarding COVID-19, Boulder Bodyworks, LLC is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfection procedures in accordance with Boulder, Colorado guidelines.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above WITHIN THE LAST 14 DAYS.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 WITHIN THE PAST 10 DAYS.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 WITHIN THE PAST 10 DAYS.

I understand that Boulder Bodyworks, LLC cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each client.

If you have tested positive for Covid, The Boulder County Guidelines say "Isolate Until: You have had no fever for at least 24 hours — without the use of fever-reducing medicines, AND your symptoms are improving, AND it has been at least 5 days since your illness began. Wear a mask for the next 5 days when around others. If you are unable to wear a mask for an additional 5 days, you must isolate for the full 10 days."

Mask Policy Effective

Treatments with Elizabeth: A KN95 or equivalent mask is required.

Acupuncture, Massage Therapy, Manual Therapy & treatments with David: Mask is optional.

Mask Policy for Pilates: Mask is optional.

For our Pilates clients: Please let us know if you have any questions. If you need to purchase a KN95 mask, we have them for purchase for \$3 each. We also have disposable medical masks available for no charge. We have medical grade air purifiers in each of the treatment rooms and in the Pilates area.

By signing below, I agree to each statement above as well as the other details of the waiver and release Boulder Bodyworks, LLC from any and all liability for the unintentional exposure or harm due to COVID-19 or any injury occurred while in the studio. Boulder Bodyworks, LLC and all instructors and staff members agree to abide by these standards and affirms the same.

(Signature of Client or Guardian): _____ Date: _____



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

We know that your time is valuable. As such, we do our best to maintain a punctual schedule. Please be aware, the practices of 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 appointment 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

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: _____