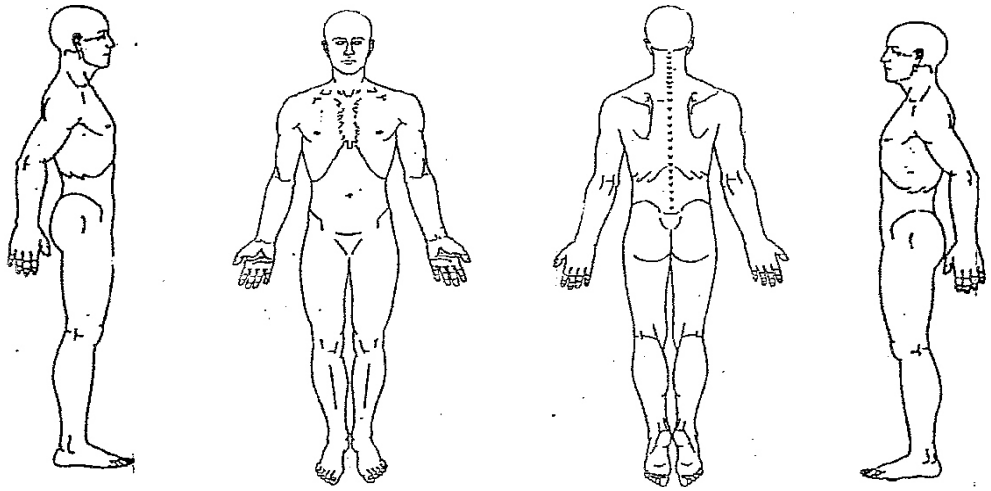
BOULDERBODYWORKS

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:
Contact Information	Emergency Contact Information	
Email:	Name:	
Mobile Number:	Relationship:	
Mobile Network Provider:	Mobile Number:	
Home Number:	Work Number:	
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:	
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

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: _____