Therapy Treatment Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Therapy Treatment Information

Have you had a professional treatment before? ☐ yes ☐ no

What type of treatment are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

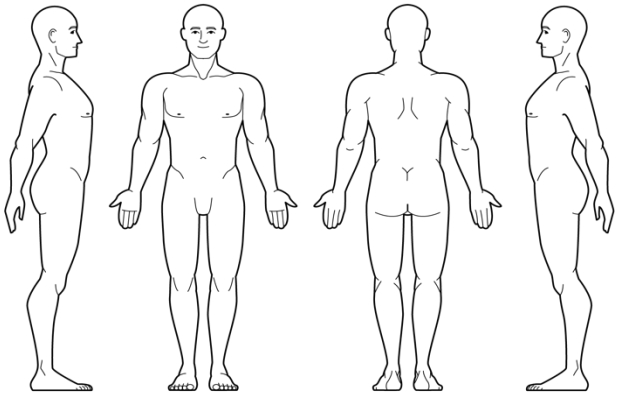
Are there any areas (feet, face, abdomen, etc.) you do not want treat? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive therapy treatment(s).
2) I understand that therapy is not a substitute for traditional medical treatment or medications.
3) I understand that the therapist does not diagnose illnesses or injuries, or prescribe medications.
4) I have clearance from my physician to receive therapy treatment(s).
5) I understand the risks associated with therapy treatment(s) include, but are not limited to:
    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury

    I therefore release the company and the individual therapist from all liability concerning these injuries that may occur during the treatment(s) session.
6) I understand the importance of informing my therapist of all medical conditions and medications I am taking, and to let the therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my therapist of any discomfort I may feel during the session so he/she may adjust accordingly.
8) I understand that I or the therapist may terminate the session at any time.
9) I have been given a chance to ask questions about the therapy session and my questions have been answered.

_____ _____

Signature Date

Precautionary Coronavirus Liability Release Form

Due to the outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitization and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry cough
- Difficulty breathing
- Chills
- Nausea or vomiting
- Diarrhea
- Confusion
- New widespread muscle pain
- Headaches
- Red or purple toes
- Loss of taste & smell
- Bruising, redness, swelling, or cramping in lower legs and feet

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 last 30 days.

I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.

I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a "hot spot" for COVID-19 infections within the last 30 days.

I understand that this business and my therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19.

Your therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitization protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Minor Release Form

All persons under the age of 18 are required to have a parent or guardian fill out this form.

By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s). You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). You will also be required, if needed, to assist the minor in preparing for his/her treatment(s). We may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor.

You also agree that you have completed the Intake Form and have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

PLEASE PRINT CLEARLY:

I _____, certify that I am the parent or legal guardian of _____, who is _____ years of age as of today. I have completed the Intake Form for the above-mentioned minor and informed the therapist of all relevant medical history and concerns. I understand the scope of therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) and agree to all the above terms.

Print Name _____

Signature _____

Date