DOCOFDETOX

Wolfe Deep Tissue Intake Form

Personal Information:

Name _____

Email _____

Phone _____

Birth Date _____

Address _____

City/State/Zip _____

Occupation _____

Employer _____

Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Conditions:

Are you currently 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 experience chronic pain? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

What makes it better? _____

_____

What makes it worse? _____

_____

Have had any orthopedic injuries? ☐ Yes ☐ No

If yes, please explain: _____

_____

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 Information

Have you had a professional Deep Tissue Treatment before? ☐ Yes ☐ No

What type of therapy are you seeking?

☐ Deep Tissue ☐ Nonsurgical ☐ Relaxation

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Are there any areas (feet, face, abdomen, etc.) you do not want worked on?

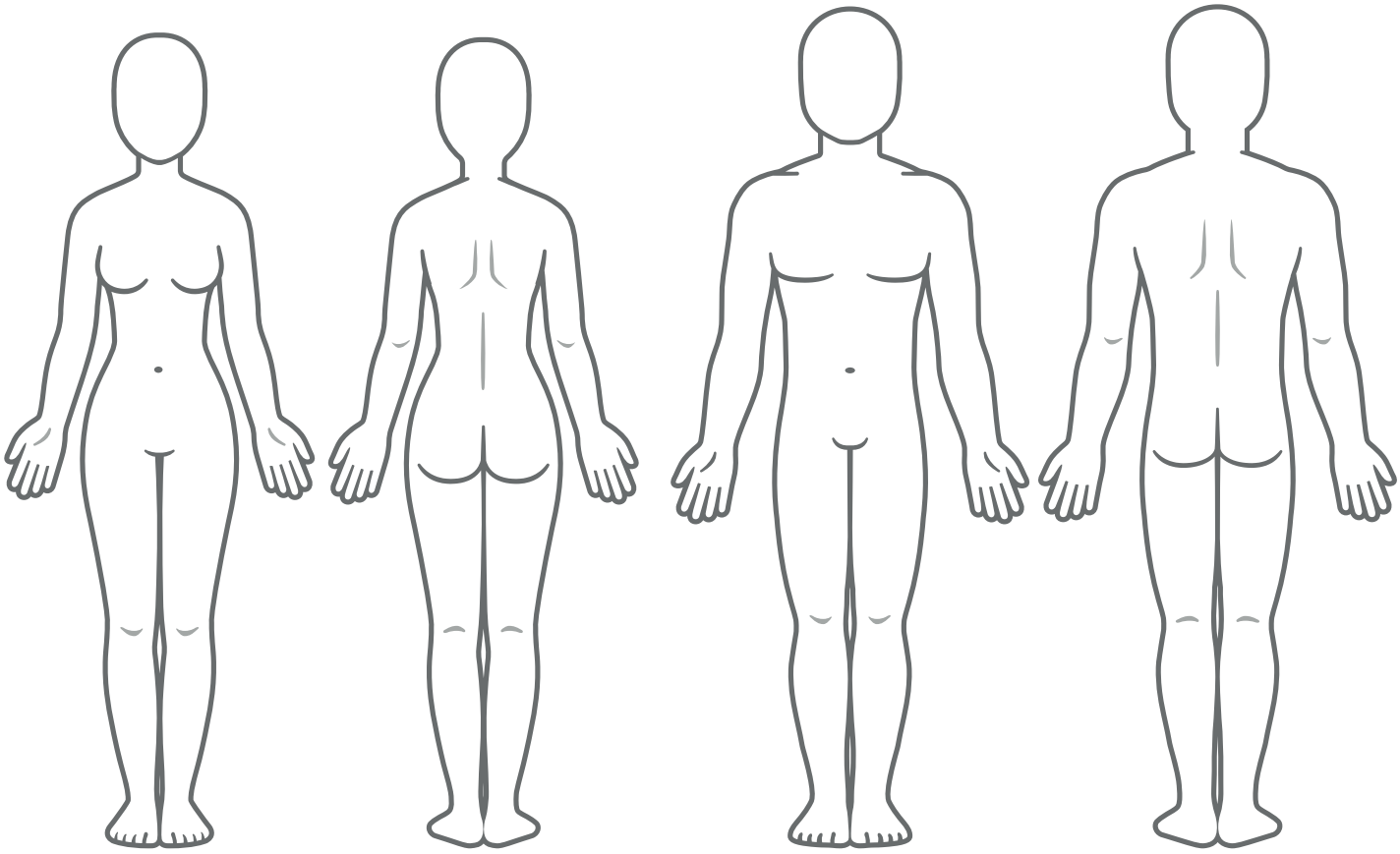
☐ Yes ☐ No

If yes, 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** _____