Client Intake Form

Personal Information:

Name: ________________________________

Address: ______________________________

____

Cell Phone: ____________________________

Work Phone: ___________________________

Email: ________________________________

Occupation: ____________________________

Date of Birth: __________________________

How did you hear about us:_________________

Emergency Contact:

Name: ________________________________

Address: ______________________________

____

Phone: _______________________________

Physician Name/Chiropractor/Other:

Name: ________________________________

Subscribe to Newsletter:____Y____N

Current Health:

Reason for Initial Visit: ____

Do you exercise regularly and/or participate in any sports? ___Yes ___ No

If yes, what kind of exercise/sport? ____

Do you perform any repetitive movement in your work, sports or hobby?

If yes, describe ____

Do you sit for long hours at a workstation, computer or driving?

If yes, describe ____

Do you experience stress in your work, family, or other aspect of your life?

If yes, describe ____

Are you experiencing tension, stiffness, discomfort or pain? ____ Yes ____ No

If yes, describe ____

Have you recently had an injury, surgery, or areas of inflammation ___ Yes ___ No

If yes, describe ____

Do you have sensitive skin? ____ Yes ____ No

Do you have any allergies to oils, lotions or ointments? ____ Yes ____ No

If yes, please explain ____

List any medications/supplements you are currently taking ____

List any known Allergies ____

Are you under any medical supervision? ____ Yes ____ No

If yes, describe ____

Health History:

Please check any of the conditions that apply or have applied:

Musculoskeletal:

__Bone or Joint disease

__Tendonitis/Bursitis

__Arthritis/Gout

__Jaw Pain (TMJ)

__Lupus

__Spinal Problems

__Broken Bones

__Migraines/Headaches

__Osteoporosis

__Range of Motion

__Loss of Balance

__Fainting Spells

Circulatory:

__Heart Condition

__Varicose Veins

__Blood Clots

__High/Low BP

__Lymphedema

__Thrombosis/Embolism

__Chest Pain

__Hepatitis

__Easy Bruising

__Cold Feet/Hands

Respiratory:

__Breathing Difficulty/Asthma

__Emphysema

__Allergies, specify:

____

__Sinus Problems

Nervous System:

__Parkinson's Disease

__Shingles

__Numbness/Tingling

__Pinched Nerve

__Chronic Pain

__Paralysis

__Multiple Sclerosis

__Parkinson's Disease

Reproductive:

__Pregnant, Stage______

__Ovarian/Menstrual Problems

__Prostate

Skin:

__Allergies, specify:

____

__Rashes

__Cosmetic Surgery

__Athlete's Foot

__Herpes/Cold Sores

__Skin Disorders

Digestive:

__Irritable Bowel Syn.

__Bladder/Kidney

__Diarrhea

__Constipation

__Colitis

__Crohn's Disease

__Ulcers

Psychological:

__Anxiety/Stress Syn.

__Depression

Other:

__Immune Disorders

__Cancer/Tumors

__Fibromyalgia

__Ears Ringing

__Diabetes

__Drug/Alcohol

__Contact Lenses

__Dentures

__Hearing Aids

__Sleep Issues

Any other medical condition(s) not listed: ____

Please Explain any of the conditions above: ____

Massage Experience:

Have you had a professional massage before? ____ Yes ____No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

____

How long have you been receiving massage therapy? ______________________________________

Frequency of massage? ____

What are your goals for treatment? ____

Pilates and Personal Training Experience:

What are your current activity/exercise habits? (i.e. weight lifting, aerobics, walking biking, etc…)

How long since your last workout? Days ______ Months ______ Years ______

____

Have you ever done Pilates or Personal Training before? _______________ For how long? _______________

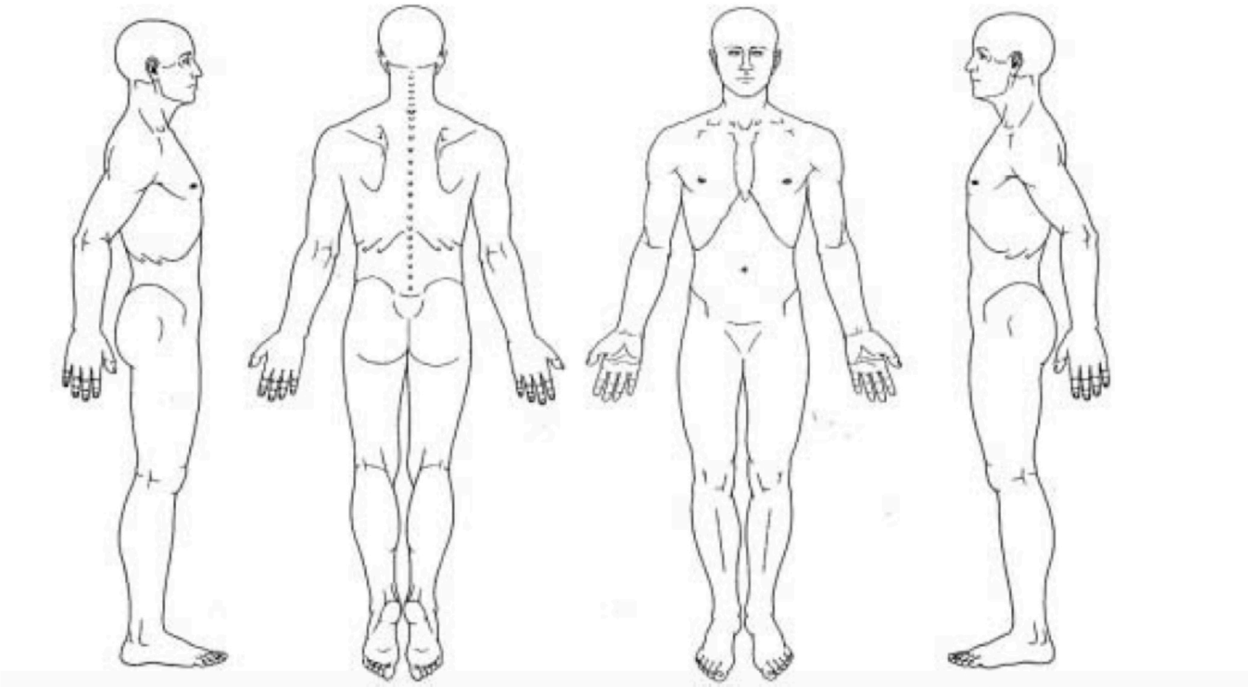
What style/level/equipment? ____

Any limitations when exercising? ____

What are your exercise and health goals? ____

Please indicate below areas you are experiencing pain or soreness or would like extra work: ___________________

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



24-Hour Cancellation Policy

Working with people to feel healthier and better about themselves is what we do best! We want the hour that you spend with us to be the best hour of your day! In order to do this, we set aside specific appointments for you for each visit.

If, for some reason, you cannot keep an appointment, we ask you to contact us at least 24 hours in advance to cancel. Otherwise, you will be charged for that visit.

I have read the above statement of policy and understand that I will be charged for any visits not kept or canceled within 24 hours of the time of my appointment.

_______________________________ _______________________________

(Signature) (Date)

Risk Waiver Form

I acknowledge that the activities in which I will participate as part of my session at Wheeler HealthyU may involve the risk of injury, pain, discomfort, and in a most severe case, death. I acknowledge that I should seek a physicians approval before participating in activities such as personal training, pilates, massage, or physical therapy at Wheeler HealthyU. I acknowledge that I need to share medical information and any changes in medical information to employees and owner, Paul Wheeler, of Wheeler HealthyU so that my course of treatment or programming can be modified or ended. I acknowledge that when I arrive at Wheeler HealthyU I waive all risks associated with being a participant in this establishment. I acknowledge that by signing this waiver, any legal action may not be taken against Wheeler HealthyU, and that I understand my risks.

____ ____

(Signature) (Date)