Confidential Health Intake Form (print double-sided) CLID:_____

Name: _____ **Year of Birth:** _____

Street Address:_____

Apt Number: _____ City:_____ State: _____ Zip: _____

Contact Phone: _____ May I send/reply via text? Yes / No

E-mail: _____ May I send you updates via e-mail? Yes / No

_____ I have seen and read the HIPPA, CAM, Prices / Policies documents and agreed to those terms and conditions. I furthermore, understand that I can request a copy of those documents at any time.

Circle any that apply to your health (professionally assessed):

Headaches / Migraines	Chronic Pain	Varicose Veins / Thin Skin	HIV/AIDS
Skin Conditions _____	Muscle / Joint Pain _____	History of Blood Clots Stroke or Hemophilia (circle any that apply)	Pregnancy: Trimester_____ (please not any restrictions)
Sinus Problems	Diabetes	High/Low Blood Pressure	Prostrate Swelling
Jaw Pain / Teeth Grinding	Sprains / Strains _____	Sleep Difficulties	Painful Menstruation
Fatigue	Scoliosis	Fibromyalgia	Tendonitis _____
Depression	Cancer (past / current) (please note below)	Arthritis	Numbness / Tingling _____
Recent Injuries (please note below)	Past Surgeries (please note below)	Heart / Breathing Problems (Please Note Below)	Are you under restricted activity orders? Yes / No

**Do you have any implant devices (including birth control) No / Yes,_____

EXPLAN ANY OF THE ABOVE / ALL MEDICATIONS / ALLERGIES / REQUIRED INTELLECTUAL ACCOMMODATIONS

_____

_____

Are you capable of sustained physical activity for up to 60 minutes? Yes / No Photosensitivity Yes / No

Preferred Pressure on a Scale of 1 - 4 (light to deep) _____ Extra Heat? Yes / No Extra Heat on Feet? Yes / No

Please circle any areas you **do not** want worked on: Scalp Abdominals Glutes Feet

Emergency Contact with Number: _____

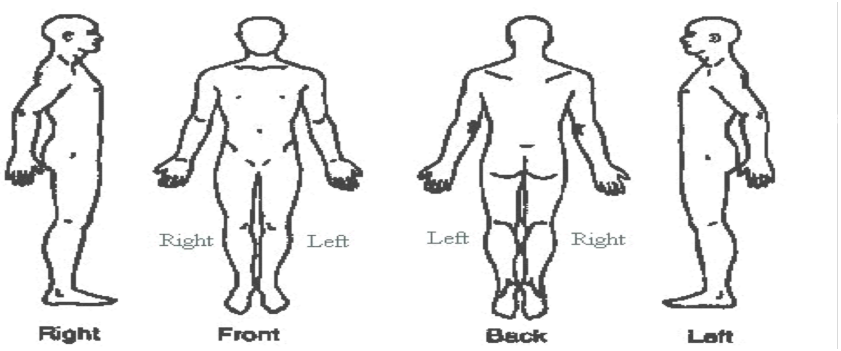
Other Requests: _____

==========STOP AT THIS LINE PLEASE==========

First Payment: DATE: _____ MOP:_____ ZIP:_____ BAL:_____

Action or Situation	Dates	Other Notes

GIANT HORIZONTAL GIANT VERTICAL



Your Goal(s)_____

Your Activity _____

Your Pofessionals_____

	Date:		Notes / Goniometer Readings
Visual	Upper Cross Syndrome	Lower Cross Syndrome	
Supine	Leg Length (short) ASIS Posterior Ium Rocking	Right / Left Right / Left Right / Left	
Muscles **(tighter)**	Hamstrings Piriformis Adductors Trapezius Levator Scapula	Right / Left Right / Left Right / Left Right / Left Right / Left	
Prone **(tighter)**	Rectus Femoris Psoas S.I. Ligament (Tender)	Right / Left Right / Left Right / Left	
Firing Order (right) **1 - 4**	Hamstrings Gluteus Max. Contralateral Erectors Ipsilateral Erectors	__ __ __ __ Y / N __ __ __ __ Y / N __ __ __ __ Y / N __ __ __ __ Y / N	
Firing Order (left) **1 - 4**	Hamstrings Gluteus Max. Contralateral Erectors Ipsilateral Erectors	__ __ __ __ Y / N __ __ __ __ Y / N __ __ __ __ Y / N __ __ __ __ Y / N	