Client Intake and Health Information Form

Date:_____

Name:_____ Sex: __Male __Female

Address:_____

City:_____State:_____ Zip: _____

Daytime Phone # _____ Cell Phone # _____

Date of Birth:_____ Occupation:_____

Martial Status: __Single __Married

Emergency Contact, Name:_____Phone # _____

Preferred Appointment Day and Time:_____

Last massage received?_____Referred by:_____

Health Information

Present symptoms: what is your major complaint or condition you want to improve:_____

_____

When did you first notice major complaints/What brought it on?_____

_____

What activities aggravate the condition?_____

_____

Is this condition getting progressively worse? __Yes __ No

Please explain:_____

Does this condition interfere with work? __Y __N, Sleep? __Y __N
Daily Routine? __Y __ N.

Please Explain:_____

_____

What have you done to get relief? _____

Has there been a medical diagnosis? __Yes __No If so, by whom? _____

_____

Are you now under medical / therapeutic treatment? __Yes __No

If yes, for what condition? _____

Please list your care provider's name and phone number:

Name:_____ Phone # _____

Permission to Consult with Primary Provider? __ Yes __No (please initial if yes)____

List any medications (including aspirin) and nutritional supplements you are taking:

_____

_____

_____

Do you have any sensitivities to oils, lotions or smells ?_____

List other therapies you receive: _____

Please list (date and description) any injuries or operations: _____

_____

_____

Have you had any recent illnesses? _____

Are you currently pregnant, if so, how long? _____

What are your expectations or intentions for this visit? _____

_____

Please list any additional comments regarding your health and well-being:

_____

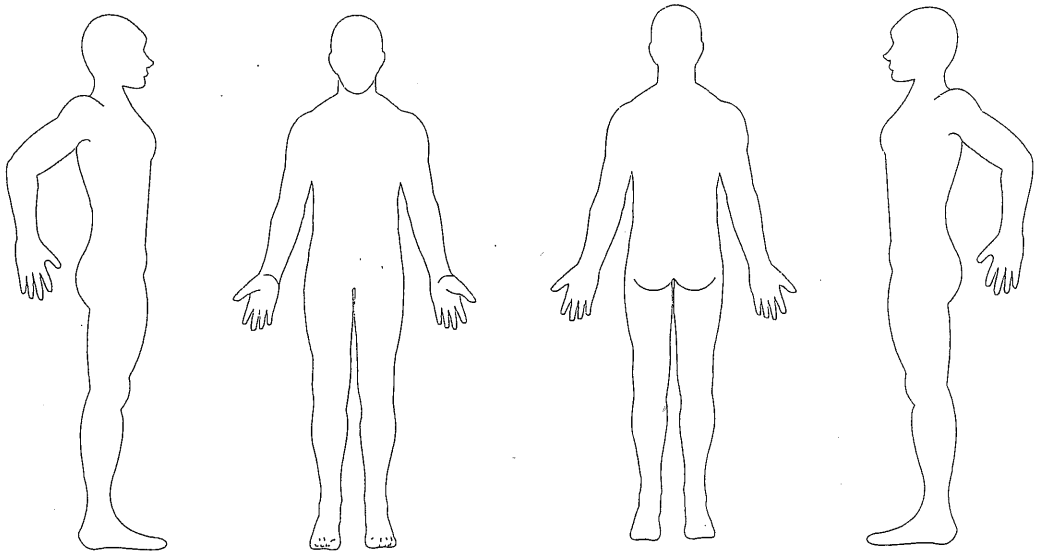
_____

Client Status Report

Name: _____ Date: _____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

Key	
	○ Circle areas where pain exists
	⊙ Circle areas with small dots where extreme pain exists
	× Put an "X" over stiff areas
	≋ Draw squiggly lines over areas of numbness or tingling
	╫ Mark scars, bruises or wounds



Right Front Back Left

Comments: _____

_____

_____

_____

_____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other: _____

Circulatory and Respiratory
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other: _____

Skin
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other: _____

Digestive
- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other: _____

Nervous System
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Other: _____

Reproductive System
- ☐ Pregnancy:
  - ☐ Current ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use _____
- ☐ Alcohol use _____
- ☐ Nicotine use _____
- ☐ Caffeine use _____
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Infectious disease (please list)

  _____
- ☐ Other congenital or acquired disabilities (please list)_____

  _____
- ☐ Surgeries _____
- ☐ Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR: My son/daughter has my permission to undergo therapeutic massage and/or ear candling at Abeler Chiropractic • Anoka, Minnesota

Printed Parent/Guardian Name _____ Date: _____/_____/_____

Parent/Guardian Signature _____

Complementary and Alternative Care
Client Bill of Rights

You should know: "The state of Minnesota has not adopted any education and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for information purposes only." "Under Minnesota law, an unlicensed complementary and alternative healthcare practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, nurse, physical therapist, nutritionist, athletic trainer or any other type of health care provider, the client may seek such services at any time."

Training and credentials of Massage Therapists

All Massage Therapists at this Clinic:

- Have more than 500 hours of Training
- Committed to ongoing education in the area of alternative and complementary health education.

Services: Provides massage therapy for the purposes of pain relief, relaxation and improved circulation among many other benefits of massage. Modalities include: Swedish, Deep Tissue, Trigger Point, Relaxation, Pre/Post Natal, Integrative and Heated Stone Massage.

****The massage Therapists do not accept insurance; they however accept referrals from licensed physicians, chiropractors or other licensed healthcare professions.**

****You have the right to reasonable notification of any rate increases**

_____Missed Appointments for Massage

When you book an appointment with us, that time is set aside for you—and ONLY you. We never double book and we try to always be ready for you when you arrive. In return, we ask that you keep your promise to us and show up for your appointment on time. Please understand that massage therapists only get paid when they deliver a service... therefore missed appointments are costly for the therapist and prevent them from catering to other clients. That said, our policy is simple... If you do not show up for your scheduled appointment, a 'missed appointment fee' of $20 will be requested.

_____Cancellations for Massage

If you are unable to keep your scheduled appointment with us, please contact us by phone at least **24 hours** prior to your appointment. If you do not reach us, please leave a message on our voice-mail system. If we do not hear from you within this time frame, and you do not keep your appointment, the above policy will be applied.

Note: We recognize that no one is perfect and there are circumstances that are out your control (sudden illness, family emergencies, etc.) and so your therapist may make an exception to the above polices on those rare occasions.

_____Client Rights:

•You have the right to decline, modify, or end the proposed treatment plan at any time
•You have the right to complete and current information concerning the therapists' assessment
•You may expect courteous treatment and be free from verbal, physical or sexual abuse
•Your client records and transactions are confidential, unless release of these records is authorized in writing by you (the client), legal guardian, or otherwise provided by law
•You have the right to assert your client rights without fear of retaliation

You have a right to file a complaint with:

Health Occupations Program
Ste. 300 golden Rule Building
PO Box 64882
St. Paul, MN 55164-0882

I acknowledge that I have received, read and agree to the client's bill of rights as required by the MN statute 146A.11

Client Signature: _____ Date: _____