Intake Form

Gene Metcalf MRT, NMT

CONFIDENTIAL CLIENT INFORMATION

Name: mike **Phone:** **Date**

Street Address: **email**

City: **State:** **Zip:**

Date of Birth: **Sex:** ☐ Male ☐ Female **Occupation:**

Physician: **Referred By:**

Primary Reason for Visit:

How long has this condition been affecting you:

Are you taking any medication: ☐ YES ☐ NO **Describe:**

Current (past) exercise athletic activities:

Goals (i.e. resuming athletic activities):

Please check the following which apply to you both past and present of aches, stiffness, tension and pain:

- ☐ Accident
- ☐ Surgery
- ☐ Neck Pain
- ☐ Whiplash
- ☐ Dizziness
- ☐ Headaches
- ☐ Head Pain
- ☐ Chest, Rib Pain
- ☐ Strains/Sprains
- ☐ Mid & Upper Back aches - Pain
- ☐ Shoulder aches - Pain
- ☐ Elbow- Wrist Hand Aches, stiffness, pain
- ☐ Carpel Tunnel Pain
- ☐ Disc Degeneration
- ☐ Low Back Pain
- ☐ Hip aches - Pain
- ☐ IT Band Tension
- ☐ Upper Leg Pain
- ☐ Hip Flexor Pain
- ☐ Lower Leg Pain
- ☐ Abdominal Pain
- ☐ Varicose Veins
- ☑ Decrease Strength
- ☐ Decrease Mobility
- ☐ Knee, ankle or Foot Pain, strains, sprained
- ☐ Heart attack/ pace maker
- ☐ Broken Bones
- ☐ Stress Fractures
- ☐ High Blood Pressure
- ☐ Breast Augmentation
- ☐ Tumors/ Cancer

other

I understand that muscular therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm and increased circulation. I understand that the treating therapist does not prescribe medical treatment, diagnose illness, disease or any other physical or mental disorder. I have been made aware that muscular therapy is not a substitute for medical examinations and or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because the treating therapist must be made aware of existing conditions I have stated all my known medical conditions and take it upon myself to keep the treating therapist updated on my physical health. I understand that regardless of insurance reimbursements, I am ultimately responsible for this account and payment is due at the time services are rendered. I understand that there is a 24-hour cancellation policy and that there is a charge for late cancellation.

Signature **Date:**

Send