Client Intake Form

Green Bay Myofascial Release Therapy & Integrated Living

Name: _____ DOB_____

Address: _____

City, State, Zip: _____

Emergency contact: _____

Phone & email : _____

Referred by: _____

Medications for what: _____

Have you experienced or are now experiencing any of the following?

_____Circulatory or heart problems
_____High blood pressure
_____Varicose Veins
_____Headaches
_____Fainting or dizziness
_____Epilepsy
_____Neurological problems
_____Numbness or tingling
_____Surgery
_____Herniated disc
_____Dislocation, sprain or strain
_____Arthritis
_____Fracture or bone trauma

_____Discomfort in back or neck
_____Pregnant
_____Anemia
_____Muscle cramping
_____Malignant conditions
_____Skin condition, lumps
_____Respiratory problems
_____Digestive problems
_____Ulcers
_____Diabetes
_____Allergies
_____Wearing dentures,
_____ Accident

Please read before signing:

I understand 24 hour notice must be given for cancellations or you may be charged.

I understand the therapist does not diagnose illness, disease nor prescribe medical treatment. I understand the therapist needs to be aware of existing physical connections therefore I will keep the therapist updated on my physical health.

Signature _____ date _____

Guardian signature_____ date _____