



Client Intake Form

Personal Information:

Name: _____

Emergency Contact:

Address: _____

Name: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Phone: _____

Email: _____

Physician Name/Chiropractor/Other:

Would you like to be added to our newsletter list? Yes No

Date of Birth: _____

Occupation: _____

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:	Respiratory:	Skin:	Other:
<input type="checkbox"/> Bone or Joint disease	<input type="checkbox"/> Breathing Difficulty/Asthma	<input type="checkbox"/> Allergies, specify: _____	<input type="checkbox"/> Immune Disorders
<input type="checkbox"/> Tendonitis/Bursitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> _____	<input type="checkbox"/> Cancer/Tumors
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Allergies, specify: _____	<input type="checkbox"/> Rashes	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Jaw Pain (TMJ)	<input type="checkbox"/> _____	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Ears Ringing
<input type="checkbox"/> Lupus	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Spinal Problems	Nervous System:	<input type="checkbox"/> Herpes/Cold Sores	<input type="checkbox"/> Drug/Alcohol
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Contact Lenses
<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Shingles	Digestive:	<input type="checkbox"/> Dentures
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Irritable Bowel Syn.	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Bladder/Kidney	<input type="checkbox"/> Sleep Issues
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Constipation	
Circulatory:	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Colitis	
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Crohn's Disease	
<input type="checkbox"/> Varicose Veins		<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Blood Clots	Reproductive:	Psychological:	
<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Pregnant, Stage _____	<input type="checkbox"/> Anxiety/Stress Syn.	
<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Ovarian/Menstrual Problems	<input type="checkbox"/> Depression	
<input type="checkbox"/> Thrombosis/Embolism	<input type="checkbox"/> Prostate		
<input type="checkbox"/> Chest Pain			
<input type="checkbox"/> Hepatitis			
<input type="checkbox"/> Easy Bruising			
<input type="checkbox"/> Cold Feet/Hands			

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 _____

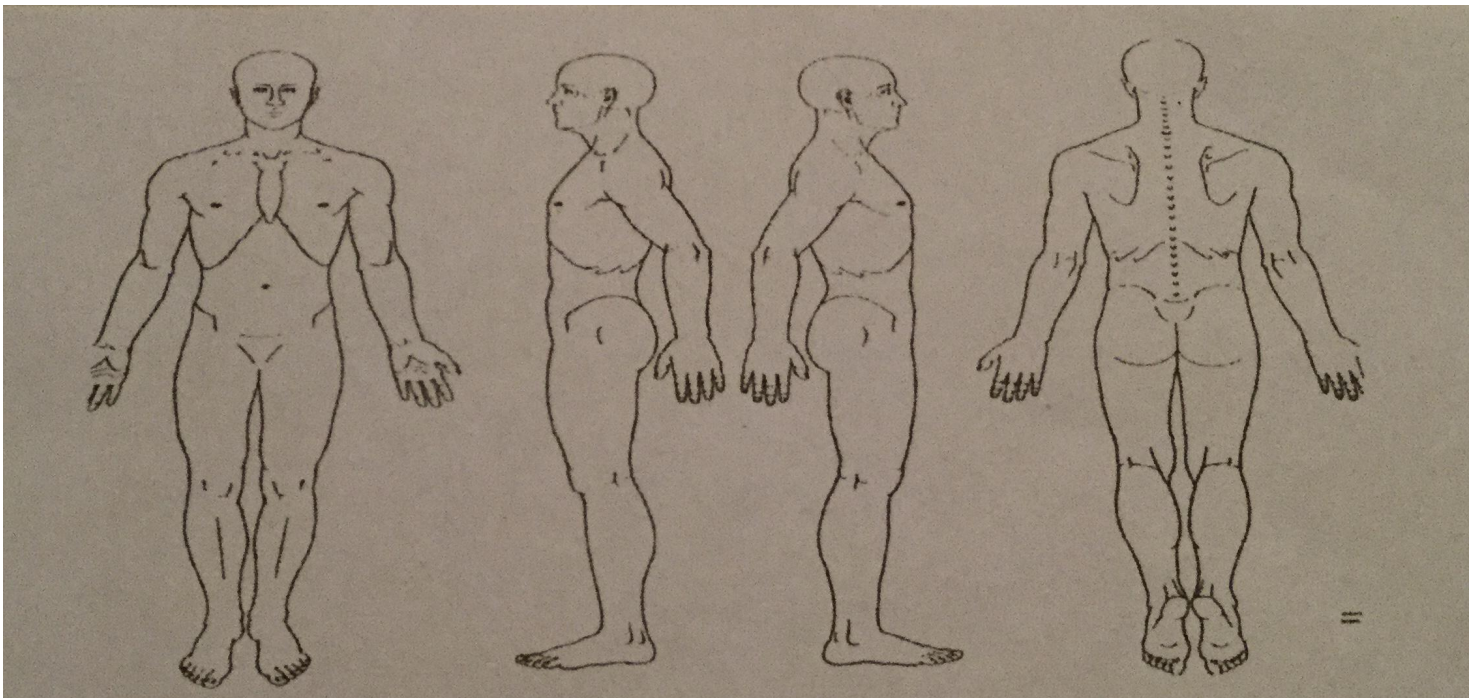
Have you ever done Pilates or Personal Training before? _____ For how long? _____

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: _____





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)