Advanced Therapeutics

Client Intake Form

client signature

date of initial visit

Personal Information

name

address

city state zip

How would you like to be contacted to confirm appointments?

home phone cell phone

work phone

email

occupation

referred by

emergency contact name emergency contact phone

physician's name physician's phone

Laser and Neuro Muscular Therapy Experience

Have you had Laser Therapy? Yes No

Have you had Neuromuscular Therapy? Yes No

What are your goals for treatment? _____

Current Health

Do you exercise regularly and/or participate in any sports? Y N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? Y N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? Y N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Y N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Y N
If yes, describe _____

Any medical diagnosis? Y N
If yes, describe _____

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions or ointments? Y N
If yes, please explain _____

List any medications you are currently taking _____

Had any cortizone shots within 1 week? Y N

List any known allergies _____

Health History (Please Check)

Musculoskeletal
- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

Circulatory
- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Respiratory
- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify: _____
- Sinus Problems

Nervous System
- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

Reproductive
- Pregnant, stage _____
- Ovarian/Menstrual Problems
- Prostate

Skin
- Allergies, specify: _____
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

Digestive
- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

Psychological
- Anxiety/Stress Syndrome
- Depression

Other
- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above :

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Client Agreement Form

It is my choice to receive Laser and Neuromuscular Therapy (NMT). I am aware of the benefits and risks of Laser and NMT as explained to me by my therapist. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques deployed during sessions.

I acknowledge that Laser and NMT is not a substitute for medical care, medical examinations, or diagnosis.

I have stated all medical conditions that I am aware of and HAVE informed my therapist of any changes in my health status. I agree to communicate any new changes that may occur to my health and I expect my therapist to provide a safe treatment to the best of her skills and knowledge.

X_____

Client Signature Date