

INTAKE FORM

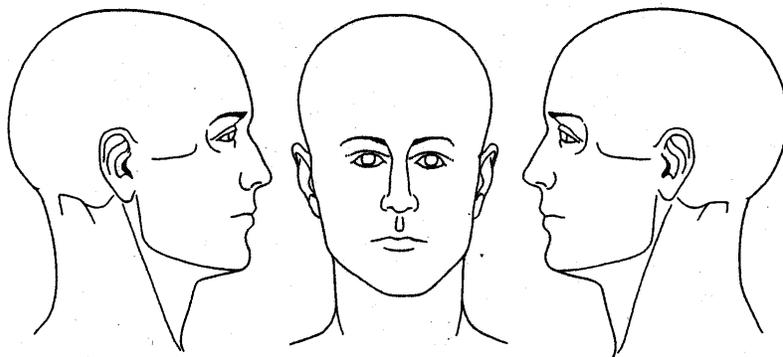
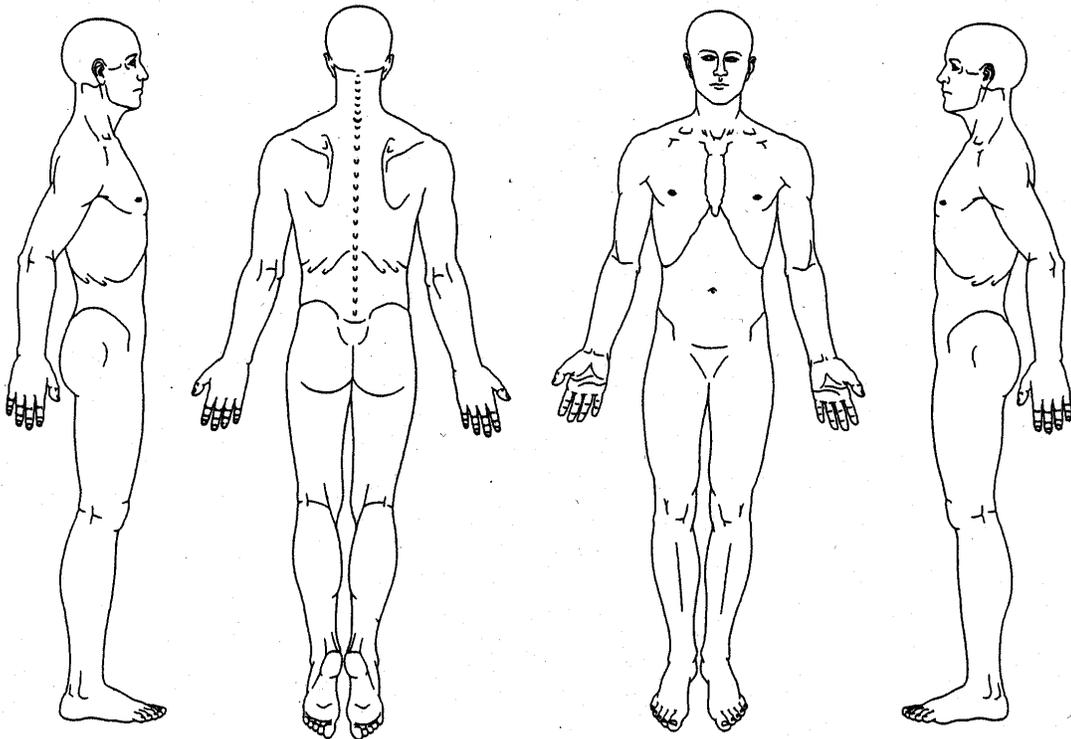
Therapist:

PAIN RECORD

NAME _____ **AGE** _____ **SEX** _____ **DATE** _____

MAJOR PROBLEM TODAY: _____

WITH RED PENCIL, COLOR THE AREAS WHERE YOU'VE HAD PAIN LATELY:



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Therapist:

Today's Date: _____

Name _____ Age ____ Birth Date _____ Marital Status _____

Address _____ Occupation _____

_____ Height _____ Weight _____

Phone (Home) _____ (Work/Cell) _____

Email _____ Referred by _____

Emergency Contact Name _____ Phone _____

Describe any chronic pain/tension. For how long?

Is your pain/tension worse in the morning or evening?

Does your work or any other activity increase your pain/tension?

Current Medical Issues and Treatments:

Past Medical Issues and Treatments:

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Therapist:

Are you currently under the care of a physician? _____

If yes, what are you being treated for? _____

Are you currently under the care of a chiropractor? _____

If yes, what are you being treated for? _____

Are you currently under the care of an alternative medicine practitioner? _____

If yes, what are you being treated for? _____

Please list any medications, vitamins and supplements you are currently taking:

Are you currently receiving any other body or energy therapies? _____

If yes, what for? _____

Please check any of the following that apply to you (in the past or currently):

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Spinal problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Disc problems |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Joint problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Accidents or Injuries |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Surgery | <input type="checkbox"/> Major illness or disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Recent breaks/sprains |

How frequently and for how long do you exercise and what do you do? Include sports, yoga, gardening, other physical activities:

Consent for Thai Bodywork Treatment

I understand that the purpose of Thai Bodywork is for relaxation and that it is not meant to diagnose or treat any illness, disease or any other physical or mental disorder, injury or condition. I have informed my Thai Bodywork practitioner about my state of health and any recommendations and restrictions on the part of my medical doctor or therapist insofar as bodywork is concerned.

Client Signature

Date

X

