

Patricia Bigler's Intake Form

Name _____ Date _____

Address _____
Street City State Zip

Date of Birth _____ Home Number _____ Cell Number _____

Email _____ Referred by _____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____ Yes _____ No

Please Explain:

Have you had a recent major surgical procedure or injury? _____ Yes _____ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

_____ Yes _____ No

Please Explain:

Please circle your stress level:

Please circle your pain level:

Low 1 2 3 4 5 High

Low 1 2 3 4 5 High

Are you allergic to any Lotions or Oils? _____ Yes _____ No

Please Explain: _____

Intake Form

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other: _____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other: _____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other: _____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other: _____

Reproductive System

Pregnancy

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophilia

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Other: _____

TRAUMA

Falls
Accidents

Send me information on your upcoming teleseminars and teleclinics. Yes / No (circle)

I understand that a massage/energy Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage/energy Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's signature _____ Date _____