ENBALANCE CLIENT INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Date of Birth: _____

Occupation: _____ Referred by: _____

General & Medical Information:
If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Have you ever had professional Rapid therapy?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Are you Pregnant?
☐ Yes ☐ No Are you Diabetic?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No Do you suffer from seizure disorder or epilepsy?
☐ Yes ☐ No Do you have a pacemaker?
☐ Yes ☐ No Do you have deep vein thrombosis?
☐ Yes ☐ No Do you have osteoperosis?
☐ Yes ☐ No Have you had any fusion surgeries?
☐ Yes ☐ No Do you have a Chemo port?
☐ Yes ☐ No Do you have any hardware or metal in your body? If so, where?
☐ Yes ☐ No Are you taking blood thinners?
☐ Yes ☐ No Have you had any broken bones in the past two years?
☐ Yes ☐ No Do you have any current fractures?
☐ Yes ☐ No Do you have any tension or soreness in a specific area?
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Do you suffer from back , neck, leg or head pain?
☐ Yes ☐ No Do you have numbness or stabbing pains anywhere?
☐ Yes ☐ No Are you sensitive to touch/pressure in any area?
☐ Yes ☐ No Have you ever had surgery? If yes, please explain in comments area of this form.
☐ Yes ☐ No Do you have any other medical condition(s) that I should be aware of?

Have you been injured in a auto accident? If yes, Date: _____ State: ____
Are you being treated for this now? ☐ Yes ☐ No
Have you had an on the job injury? If yes, Date: _____ State: ____
Are you being treated for this now? ☐ Yes ☐ No

Comments:

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.
If you have a specific medical condition or specific symptoms, manual therapy may be contraindicated. A referral from your primary care provider may be required prior to service being provided. I understand that manual therapy I receive is provided for the basic purpose of relief of pain and soft tissue dysfunction. If I experience any potential injury during this session, I will immediately inform the therapist so that the therapist may adjust therapy accordingly. I further understand that massage/ bodywork should not be construed as a substitiute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork therapists are not qualfied to perform spinal or skeletal adjustments, diagnose, or prescribe. And that nothing said in the course of the session should be construed as such. Because manual therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and I have followed my doctor's orders or suggestions for further medical testing. I have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appoitment. I hereby provide my

Client's Signature: _____ Date: _____

Information and Suggestions for the Client:

During your session, you may want to give your therapist feedback as to pressure (deeper or lighter if pain tolerance is low) or point out painful or sensitive areas.
Feel free to ask your therapist any questions about their procedures. Your therapist is a highly trained professional and will be happy to make you feel well informed and comfortable.