**CLIENT INFORMATION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Middle Initial)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Gender: M F Age: \_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Time and Place to Reach You:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**

**1**

**CLIENT CONDITION**

**3**

Reason for consulting the clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment have you already received for your condition?

□ Medication □ Surgery □ Physical Therapy □ Chiropractic □ Massage □ None □ Other \_\_\_\_\_\_\_\_\_\_\_

Diagnostics Tests/ Reports for this injury:

□ X-rays @ \_\_\_\_\_\_\_\_ □ MRI @ \_\_\_\_\_\_\_\_\_\_ □ CT Scan @ \_\_\_\_\_\_\_\_\_\_ □ Surgery @ \_\_\_\_\_\_\_\_\_\_\_

Type of Pain:

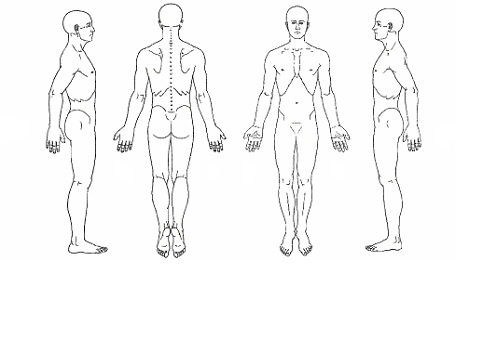
□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ None

□ Burning □ Cramps □ Stiffness □ Tingling □ Swelling □ Other: \_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation □ Sport

How often do you have this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Constant? □ Intermittent?

**4**

[](http://www.google.com/url?sa=i&rct=j&q=health%20intake%20form&source=images&cd=&cad=rja&docid=jbpbPmpEyjx3_M&tbnid=l7oWib97RCh7YM:&ved=0CAUQjRw&url=http://www.flickr.com/photos/ladyravenscreations/4219925618/&ei=FVHtUb6PLIrgyQGRnoHgDQ&bvm=bv.49478099,d.aWc&psig=AFQjCNG6rIcSFFDL4u9gwLUnbZ90ZG4v8w&ust=1374593671012031)

Please shade in the area in which you are having pain or difficulty for which you consulted this clinic.

**5**

On the scale below, please mark a dash to indicate the level of pain at the present time.

10

5

0

Severe Pain

Absence of Pain

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please check the conditions or symptoms you currently have or have had in the past: | | | | |
| □ Anemia | □ Cancer | □ Hepatitis | □ Multiple Sclerosis | □ Sinus Problems |
| □ Anorexia | □ Chemical Dependency | □ Hernia | □ Osteoporosis | □ Stroke |
| □ Appendicitis | □ Diabetes | □ Herniated Disc | □ Pacemaker | □ Tendonitis |
| □ Arthritis | □ Emphysema | □ Herpes | □ Parkinson’s | □ Thyroid Problems |
| □ Asthma | □ Epilepsy | □ High Blood Pressure | □ Pinched Nerve | □ Tuberculosis |
| □ Blood Clots | □ Fibromyalgia | □ HIV/AIDS | □ Pneumonia | □ Tumors, Growths |
| □ Breathing Difficulty | □ Fractures | □ Jaw Pain/ TMJ | □ Polio | □ Ulcers |
| □ Bursitis | □ Glaucoma | □ Lymphedema | □ Prosthesis | □ Varicose Veins |
| □ Bronchitis | □ Head Injuries | □ Migraines | □ Rheumatoid Arthritis | □Whiplash |
| □ Bulimia | □ Heart Disease | □ Mononucleosis | □ Seizure | □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**6**

**HEALTH HISTORY**

SURGERIES: (Surgery/Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS: (Meditation/ Reason for Taking)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VITAMINS/MINERALS/HERBS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIFESTYLE

□ Smoking Packs/Day \_\_\_\_\_ □ Coffee/ Caffeine Cups/Day\_\_\_

□ Alcohol Drinks/Week \_\_\_\_ □ High Stress Level

WORK ACTIVITY

□ Sitting □ Light Labor

□ Standing □ Heavy Labor

EXERCISE

□ None □ Moderate

□ Daily □ Heavy

I, the patient, (or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian) voluntarily consent for care provided to me by iBackCheck Sport Therapy. I understand care encompasses evaluation and treatment techniques as recommended by my provider. I acknowledge that no guarantees have been made to me about the results of the care at iBackCheck Sport Therapy.

I authorize payment to be made on my behalf to iBackCheck Sport Therapy for care. I agree to pay the charges for care rendered to me that are not covered by insurance or any other third party.

I authorize iBackCheck Sport Therapy to release medical information regarding myself to my insurance company, employer and other medical providers involved in my care. In addition, the following individuals may have access to my medical information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the use of still photography or video analysis as a component of my care. I will be made aware that these photographs or videos are being taken.

I have seen or can receive a copy of the HIPAA Privacy Policy upon request

CANCEL / NO SHOW POLICY: I have read and understand iBackCheck Cancel/ No Show Policy.

I have read the above noted consent and have had the opportunity to ask questions. I understand that at any time I may withdraw my consent and treatment will be stopped.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client, Parent, or Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Name of Client, Parent, or Guardian Relationship to Client

**7**

**AUTHORIZATION**