



4. Have you ever received other treatments for this condition? If yes, please indicate the type of treatment, length of treatment and effectiveness.

5. What activities or positions increase your pain and what activities or positions decrease your pain?

6. Mark the line below to indicate the INTENSITY of your symptoms currently.

None \_\_\_\_\_ Worst Possible

7. Put 2 marks on the line below to indicate the BEST and WORST your symptoms have been in the past week.

None \_\_\_\_\_ Worst Possible

8. Mark the line below to indicate the FREQUENCY of your symptoms.

Never \_\_\_\_\_ Constant

9. Mark the lines below to indicate your daily functional ability as a percentage of normal.

On a "good day": 0% \_\_\_\_\_ 100%

On a "bad day": 0% \_\_\_\_\_ 100%

10. What are your goals for therapy?

11. Please list any surgeries, accidents or traumas (physical or emotional) and the dates of occurrence.

12. Do you have any implanted medical device?

13. Please list all medications that you are currently taking, the problem for which you are taking them.

14. Please check any of the conditions that you have or have had in had in the past. Mark with a "c" if current and with a "p" if in the past.

**MAJOR MEDICAL**

Heart Disease  
Cancer  
High/Low Blood Pressure  
Diabetes  
Stroke/CVA  
Epilepsy/Seizures  
Lung Disease  
Aneurysm

**CIRCULATORY**

Hypertension  
Edema  
Reynaud's Disease  
Varicose Veins  
Heart Attack  
Cardiovascular Disease  
Blood Clots  
Bleeding Disorder  
Diabetes (Type 1 or 2)

**DIGESTIVE**

Ulcers  
Colitis  
Gallstones  
Hepatitis/Liver Disease  
Constipation  
Diarrhea  
Gas/Bloating  
Indigestion/Heartburn  
IBS/Cohn's Disease

**NERVOUS SYSTEM**

Shingles  
Multiple Sclerosis  
Parkinson's Disease  
Bell's Palsy  
Spinal Cord Injury  
Seizure Disorders  
Numbness/Tingling

**RESPIRATORY**

Pneumonia  
Sinus Problems  
Allergies  
Asthma

**SKIN**

Fungal Infections  
Impetigo  
Dermatitis/Eczema  
Psoriasis  
Cosmetic Surgery

**UROGENITAL**

Coccyx Pain  
Pain with intercourse/Dysparuenia  
Cystitis/Chronic UTI  
Painful Urination  
Frequent Urination  
Kidney Disease  
Endometriosis  
Fibroids  
Menstrual Issues

**PAIN CONDITIONS**

Arthritis (Osteo/Rheum)  
Bursitis  
Headaches/Migraines  
TMJ/Jaw Pain  
Low Back Pain  
Neck Pain  
Knee Pain  
Hip Pain/Pelvic Pain  
Rotator cuff problems  
Sciatica  
Pinched Nerve  
Thoracic Outlet Syndrome  
Carpal Tunnel Syndrome  
Plantar Fasciitis  
Fibromyalgia  
Spasms/Cramps  
Sprains/Strains  
Tendonitis  
Whiplash

**OTHER**

Osteoporosis  
Hernia  
Difficulty Sleeping  
Tinnitus  
Sleep Apnea  
Dizziness/Vertigo  
Anxiety/Panic Attacks  
Depression  
Thyroid Condition  
HIV  
Lupus

Other:

15. Are you currently pregnant or there a possibility you may be pregnant?

## **CONSENT TO TREAT**

I give Dana Fonte permission to provide treatment that will include manual therapy and therapeutic exercise. I understand that in order for me to fully benefit from the treatment provided, I will have to participate on my own behalf outside of my treatment sessions. This might include performing self-myofascial treatment, to progress my healing process.

In order for my therapist to most effectively treat me with manual therapy, I may be asked to remove some clothing or wear little clothing during treatment. I understand that if I am uncomfortable with this, I will share my concerns with my therapist and she will bide by my request.

I acknowledge that Dana Fonte must be fully aware of my existing medical conditions. I have completed the client intake form and have disclosed, to the best of my knowledge, all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I have read the above noted consent. By signing this form, I consent to treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **CANCELLATION POLICY**

I understand that each appointment I have scheduled is very important either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Dana Fonte within 24 hours if I need to cancel an appointment. If I am unable to do this I understand that I will be responsible for payment for the scheduled time unless Dana is able to fill the appointment time.

I have read and understand this cancellation policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CLIENT INTAKE DIAGRAM

Please identify areas of soreness or pain with a (P), numbness or tingling (N), weakness (W), and scars (S).

