CLIENT INTAKE FORM FOR RESTORATIVE THERAPIES

Name:_____ Male Female Date:_____
Home address: _____
Phone: Home: _____ Cell: _____
Birthdate: _____
Primary Care Physician: _____
Emergency Contact (Name / #): _____

HEALTH HISTORY

Do you currently have or have you ever had any of the following conditions?:

Y N Recent Surgery	Y N Pins/Plates/Metal Implants	Y N Current Open Wounds
Y N Currently Pregnant	Y N Currently Breastfeeding	Y N Cancer
Y N Diabetes	Y N Congestive Heart Failure	Y N Pacemaker / Defibrillator
Y N Epilepsy / Seizures	Y N Pulmonary Edema	Y N Pulmonary Embolism
Y N Acute Thrombophlebitis	Y N Atherosclerosis	Y N Ischemic Vascular Disease
Y N Acute Infections	Y N Deep Vein Thrombosis DVT	Y N Cellulitis
Y N Current Fractures	Y N Current Contusions/ Abrasions	Y N Dermatitis/Skin conditions
Y N Lymphangiosarcoma	Y N Hyperthyroidism	Y N Herpes
Y N Photosensitivity	Y N Lasik Eye Surgery	Y N Facial Fillers / Botox
Y N Tattoos	Y N Breast Implants	Y N Laser Hair Removal
Y N Multiple Sclerosis	Y N Central Nervous System Tumors	Y N Hemophilia
Y N Current Fever	Y N COPD	Y N Pneumothorax
Y N Sickle Cell Anemia	Y N Hereditary Spherocytosis	Y N High Blood Pressure
Y N Angina / Chest Pain	Y N Severe/ Frequent Headaches	Y N Asthma
Y N Osteoporosis	Y N Osteoarthritis	Y N Rheumatoid Arthritis
Y N Stroke	Y N Kidney Disease	Y N Sinus Problems
Y N Depression	Y N Compressive Brain Lesion - subdural or intracranial hematoma	
Y N Fibromyalgia	Y N Claustrophobia	Y N Decompression Sickness
Y N Problems equalizing (popping) ears		

Please list surgeries:

_____

_____

Are you currently taking any of the following medications?:

Y N Tetracycline	Y N Cigoxin	Y N Retin A	Y N Other Photosensitive Drugs
Y N Diuretics	Y N Barbiturates	Y N Beta Blockers	Y N Antihistamines
Y N Amitriptyline	Y N Other Anticholinergic Drugs	Y N Steroids	Y N Heat Producing Balms

List any other medications that you are taking: _____

_____

I understand the above information and guarantee that it was completed to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____