Theraspring
Myofascial Release Healing Center

49 Walnut Park, Building #5
Wellelsey, MA 02481

Client Intake Form

Date_____ Practitioner_____

Name_____ Date of Birth_____ Pronouns Preferred_____

Address_____City_____State_____Zip_____

Phone Number (day)_____(evening)_____

Email Address_____ Referred by_____

Emergency Contact_____Phone_____Relationship_____

Primary Care Physician_____Phone_____

What is the reason for seeking services?

What symptoms do you have?

What are your goals?

Circle any of the following conditions that you have and describe below:

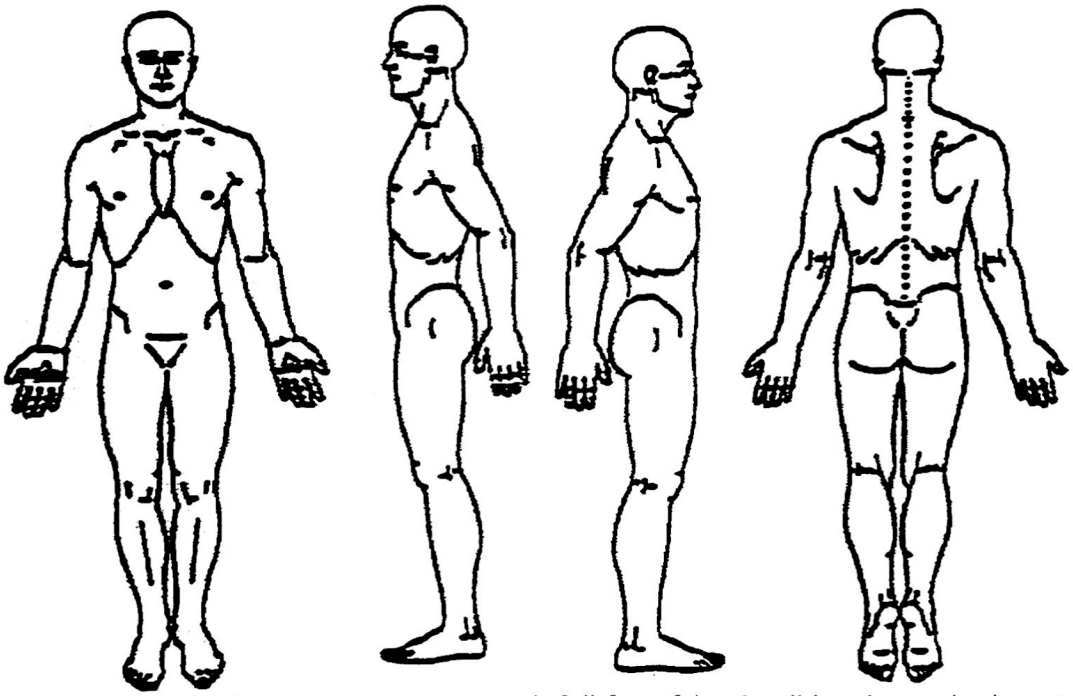
Allergies	Cold Sweats	Muscle Strain/Sprain	Stress
Arthritis	Contact Lens	Neuritis	Scoliosis
Anemia	Diabetes	Phlebitis/Blood Clots	Varicose Veins
Anxiety	Digestion Problems	Pins/Pacemaker	Vertebral/Disc
Asthma	Endocrine Issue	Pregnancy	
Bleeding/Bruising	Fatigue	Psychiatric	
Blood Pressure Problems	Headaches	Respiratory	
Bursitis	Hernia	Seizures/Epilepsy	
Cancer	Joint Problems	Sinus Problems	
Cardiac Issues	Kidney/Urinary	Skin Conditions	
Circulation Problems	Liver/Gall Bladder	Smoker	

Briefly explain all conditions that you circled above:

Please list any hospitalizations, surgery, or serious injuries you have had and when they occurred. Please include broken bones and motor vehicle accidents.

Please mark on the drawings below the areas where your pain is and where you hold your tension.
Please indicate your level of pain 0-10 _____

LEFT SIDE RIGHT SIDE



A 24 hour cancelation notice is required, full fee of $140 will be charged otherwise.

Client Signature (Client/Parent/Guardian) Date Relationship to Client

HIPPA

ACKNOWLEDGE TO NOTIFICATION OF PRIVACY PARACTICES, AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION. I understand that Theraspring, has a Notice of Privacy Practices that describes how my health care information is used and shared with others. I understand that I have a right to request a copy of the Notice and that I have a right to read the Notice before signing this consent.

By signing below, I acknowledge the notification of Theraspring's Notice of Privacy Practices and consent to the uses and discloser therein.

Client Signature (Client/Parent/Guardian) Date Relationship to Client