Denver Pain and Performance Solutions – Confidential New Client Intake

Name: _____ Date: _____
Full Address: _____
Phone: _____ Email: _____
Date of Birth: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Describe your current activity level:

_____

Are you currently under the care of a physician? (If yes, please explain.)

_____

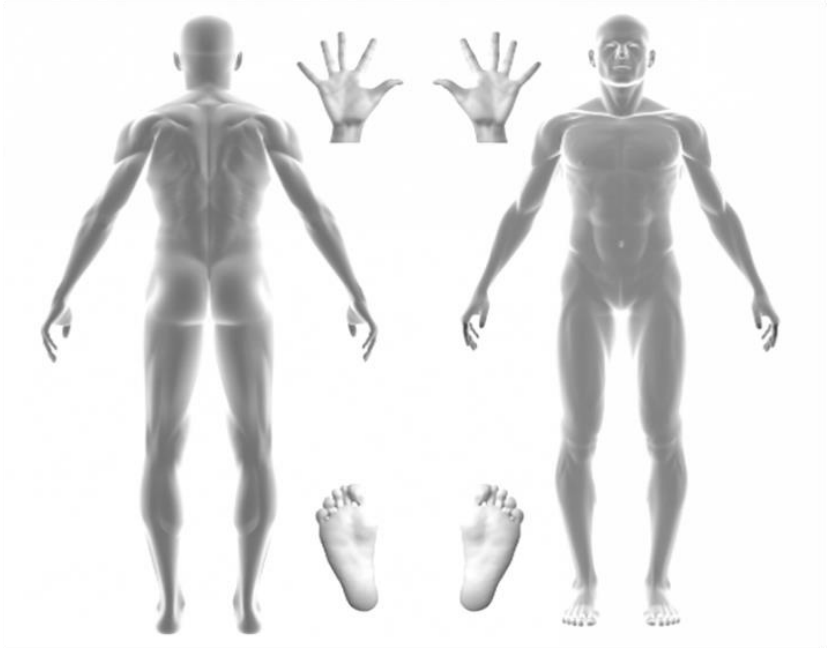
Please list past and present injuries, including surgeries:

_____
_____
_____
_____
_____

What is your primary reason for seeking treatment?

_____
_____
_____
_____

Please mark areas of pain, scarring (surgical or non-surgical), tattoos, and piercings on the diagram below:



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Please mark any of the following conditions that currently apply to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/arthritis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnant
If yes, how many months?

Please let us know how you heard about us:

( ) Direct Referral (Please specify: _____)
( ) Provider search at www.activerelease.com
( ) Internet search (Please specify search terms: _____)
( ) Other (Please specify: _____)

Disclaimer: The integrated treatment I receive from Denver Pain and Performance Solutions is for my relief of pain associated with soft tissue and motor control dysfunction. I will immediately inform the provider of any pain or discomfort so that pressure can be adjusted to my level of tolerance. I understand that this treatment is not a substitute for medical examination, diagnosis, or treatment by a medical doctor. I understand that LMT's are not qualified to perform spinal or skeletal adjustments, or to diagnose or prescribe treatment for any physical or mental illness. Because treatment should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and 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 therapist's part should I fail to do so.

Client Signature: _____

Date: _____