



Client Contact Information

Client name: _____ Date: _____

Date of birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health Care Provider: _____ Phone: _____

Patient Health Information

Is this manual therapy medically necessary (is it for a medical condition, injury, surgery)? Yes No

Do you have a physician referral/prescription? Yes No

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness, swelling, etc).

Do these symptoms interfere with your daily activities (e.g., sleep, exercise, work, childcare)? Yes No

If yes, explain:

List any medications that you currently take:

Have you had any injuries in the past that may influence today's treatment? Yes No

Circle any of the following health conditions that you currently have. (If you are unsure, please ask.)

blood clots infections congestive heart failure contagious diseases pitting edema

Please answer honestly, as manual therapy may be contraindicated or special precautions may need to be taken for the above conditions.

Health History

Please circle any conditions that you have or have had in the past. Explain in detail, including treatment received, in the space provided below.

Current Past Muscle or joint pain

Current Past Muscle or joint stiffness

Current Past Numbness or tingling

Current Past Swelling

Current Past Bruise easily

Current Past Sensitive to touch/pressure

Current Past High/Low blood pressure

Current Past Stroke, heart attack

Current Past Varicose veins

Current Past Shortness of breath, asthma

Current Past Cancer

Current Past Neurological (e.g., MS Parkinson's)

Current Past Epilepsy, seizures

Current Past Headaches, migraines

Current Past Dizziness

Current Past Digestive conditions (e.g., Crohn's, IBS)

Current Past Gas, bloating, constipation

Current Past Kidney disease, infection

Current Past Arthritis (rheumatoid, osteoarthritis)

Current Past Osteoporosis, degenerative spine/disk

Current Past Scoliosis

Current Past Broken bones

Current Past Allergies

Current Past Diabetes

Current Past Endocrine/thyroid conditions

Current Past Depression, anxiety

Current Past Memory loss, confusion

Current Past Easily overwhelmed

Detailed explanation of conditions and treatment:



Consent for Treatment

If I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the treatment may be adjusted to my level of comfort. I further understand that manual therapy should not be construed as a substitute for proper medical care or diagnosis, and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that my manual therapy practitioner is not qualified to perform spinal or skeletal adjustments, to diagnose, prescribe, or treat any physical or mental illness, and that nothing discussed in the course of the session should be construed as such.

Because manual therapy should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that an open line of communication with my practitioner is essential in ensuring that I get the best care possible.

Understanding all of this, I give my consent to receive care.

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature (in case of minor) _____ Date: _____

I have received a copy of Sadhana's Policies and Procedures.

Signature: _____ Date: _____

