Sādhanā
integrative manual therapies

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: _____