Patient Intake Form

CHAY MISSION LLC

Name_____ Preferred # ( ) _____ Cell Home

E-mail: _____ DOB _____ Age: _____

Address _____ City_____ State _____ Zip _____

Referred by:_____ Phone (_____)_____

In case of emergency:_____ Phone (_____)_____

Occupation_____ Physician_____ Phone (___)_____

Carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, techniques may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

List your goals for these sessions

List your areas of tension / soreness

Date of last physical, well-check _____ Date of last blood work _____

Do you have / have you had…

O Yes	O No	stress?
O Yes	O No	diabetes?
O Yes	O No	frequent headaches?
O Yes	O No	arthritis?
O Yes	O No	back pain?
O Yes	O No	cardiac or circulatory conditions?
O Yes	O No	high blood pressure?
O Yes	O No	Are you taking blood pressure medication?
O Yes	O No	cancer?
O Yes	O No	epilepsy or seizures?
O Yes	O No	joint swelling?
O Yes	O No	varicose veins?
O Yes	O No	osteoporosis / osteopenia?
O Yes	O No	broken bones? History of fractures?
O Yes	O No	metal implants?
O Yes	O No	DVT (blood clots)? Where? _____
O Yes	O No	injuries?
O Yes	O No	Do you bruise easily?
O Yes	O No	nerve damage
O Yes	O No	ADHD
O Yes	O No	Autism Spectrum Disorder
O Yes	O No	septicemia
O Yes	O No	Dentures, false teeth, retainers, dental implants, partials, crowns, wisdom teeth, oral surgeries
O Yes	O No	any contagious diseases / infections? Hepatitis, MRSA, staphylococcus, HIV / AIDS, _____
O Yes	O No	numbness or stabbing pains?
O Yes	O No	sensitivity to touch or pressure in any area?
O Yes	O No	any allergies?
O Yes	O No	increased intracranial pressure?
O Yes	O No	spina bifida (myelomeningocele)?
O Yes	O No	Arnold Chiari Malformation?
O Yes	O No	acute stroke? Date of stroke _____
O Yes	O No	cerebral aneurysm?
O Yes	O No	hemorrhage?
O Yes	O No	herniated medulla oblongata?
O Yes	O No	skull fracture? Facial trauma?
O Yes	O No	cerebrospinal fluid leak?
O Yes	O No	fallen?
O Yes	O No	been in a car accident? When _____
O Yes	O No	dizzy spells?
O Yes	O No	Are you wearing contact lenses?
O Yes	O No	Are you currently pregnant?
		How many pregnancies including miscarriages ____
O Yes	O No	Poor bone density?
O Yes	O No	Ringing in ears
O Yes	O No	Meniere's disease
O Yes	O No	Whiplash, neck or spinal injuries / surgeries
O Yes	O No	Epidural, spinal anesthesia, lumbar puncture, complications

List joint dislocations / injection location

_____

_____

→ → → Please continue onto next page → → →

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- Please list additional medical conditions / surgeries

- Please list medications.

- Please list contraindications from your physician, surgeon, etc.

Comments _____

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept confidential. I understand that the techniques I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that these techniques should not be construed as a substitute for medical examination, diagnosis, or treatment 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 these practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because these techniques 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I hereby give my consent to receive services from Chay Mission LLC and I acknowledge and agree I am doing so at my own risk. My decision to receive services from Chay Mission LLC is voluntary, and I know of, understand and assume any and all the risks associated therewith. In exchange for receiving services from Chay Mission LLC, I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless Chay Mission LLC, its members, officers, employees, business associates, agents, and premises used for Chay Mission LLC business from any and all liability for any and all injuries, including death, damages, actions, causes of action or claims relating to or resulting from my receipt of services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold Chay Mission LLC, its members, officers, employees, business associates, agents, and premises used for Chay Mission LLC business harmless from and against any and all claims, actions, causes of action, rights, damages, liabilities, losses, costs and expenses (including reasonable attorney fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

I understand that my information will stay confidential with Chay Mission LLC members and business associates.

I acknowledge that I have read, and understand, the release and indemnification provisions set forth in the preceding paragraphs and agree to such terms.

Client Signature_____Date _____

Chay Mission LLC Member Signature_____Date _____

Consent to Treat Minor: By my signature below, I hereby authorize Chay Mission LLC Member to administer therapy techniques and somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____