

# Great Strides Rehabilitation

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## Client Intake Form

Date \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Contact Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Emergency Contact (Name and Phone Number) \_\_\_\_\_  
Referred By \_\_\_\_\_

## Health Data

Reason For Visit \_\_\_\_\_ Allergies \_\_\_\_\_  
Medications Your Are Taking (prescription and non) \_\_\_\_\_  
Recent Surgeries, Illnesses, and Injuries Within The Past Year \_\_\_\_\_  
Any Injuries Within Past 72 Hours? \_\_\_ Yes \_\_\_ No Explain \_\_\_\_\_

### Check All That Apply:

- |   |   |
|---|---|
| <input type="checkbox"/> breathing problems (lungs)           | <input type="checkbox"/> pregnant or nursing              |
| <input type="checkbox"/> bruise easily                        | <input type="checkbox"/> psychotherapy                    |
| <input type="checkbox"/> cancer w/in past 5 years             | <input type="checkbox"/> sensitive to cold/heat/pressure  |
| <input type="checkbox"/> carpal tunnel                        | <input type="checkbox"/> sciatica                         |
| <input type="checkbox"/> contact lenses                       | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> diabetes                             | <input type="checkbox"/> sinuses                          |
| <input type="checkbox"/> exercise - frequency _____           | <input type="checkbox"/> skin conditions _____            |
| <input type="checkbox"/> heart problems                       | <input type="checkbox"/> suffer from stress               |
| <input type="checkbox"/> high blood pressure                  | <input type="checkbox"/> tobacco products                 |
| <input type="checkbox"/> last alcohol consumption _____       | <input type="checkbox"/> TMJ (jaw pain)                   |
| <input type="checkbox"/> migraines                            | <input type="checkbox"/> trauma or motor vehicle accident |
| <input type="checkbox"/> numbness or tingling - area(s) _____ | <input type="checkbox"/> under physicians care            |
| <input type="checkbox"/> pacemaker                            | <input type="checkbox"/> varicose veins                   |

Informed Consent: The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to inform the therapist of any experience of pain during the session. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, and treatment, and that I should see a medical or chiropractic physician or other healthcare specialist. I agree to update the therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Please Provide A Copy Of Your Driver's License Or Identification Card \***