C.A.F.E. OF LIFE CHIROPRACTIC * Dr. Alfonso Di Carlo

CLIENT INTAKE FORM – MUSCLE THERAPY

Patient Contact

Preferred to be called_______________________________Date________________________

Last name________________________First name_________________________m.i.________

Address ___________________________City _________________State______Zip ________

Phone: (H) ________________ (W) ______________E-mail _________________________

Emergency Contact___________________________Phone_____________________________

Patient Personal

Date of Birth____________________ Age_______Occupation___________________________

Sex ❒ male ❒ female Status ❒ single ❒ married ❒ widowed ❒ separated ❒ partnered ❒ divorced

1. Have you had a professional muscle therapy/massage session before? Yes No
If yes, how often do you receive muscle therapy?_______________________________________

2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe____

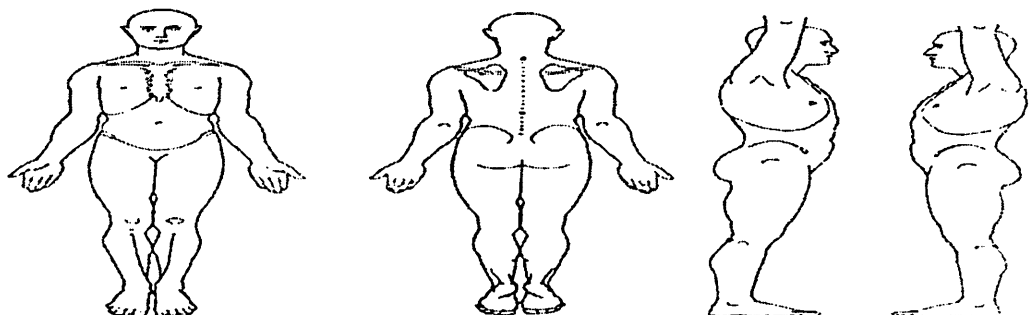
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?muscle tension( ) anxiety( ) insomnia( ) irritability( ) other

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort
f yes, please explain____

Using the scale below, rate how your primary complaint affects your life.(**circle** only one below)

1	2	3	4	5	6	7	8	9	10
Mild, noticeable pain. Mostly don't think about it.	Minor pain. Annoying. Occasional stronger twinges.	Pain is noticeable& distracting. Get used to it and adapt	Moderate pain that is distracting my daily activities	Moderate pain that prevents performing some of my daily activities	Moderately strong pain interferes w/ normal activities. Difficulty concentratin g	Severe pain. Social activities affected. Interferes w/ sleep.	Intense pain limits physical activity. Conversing requires great effort	Excruciating pain. Inability to have Conversation Crying out/ moaning constantly	Unspeakable pain. Bedridden and possibly delirious.

Please mark the areas of all your complaints on the diagrams on the right. include any descriptors or comments, concerning your health complaints that were not mentioned above.



System review:

General

☐ consistent fainting	☐ dizziness	☐ tension	☐ depression
☐ loss of sleep	☐ fatigue	☐ fever	☐ headache
☐ loss or weight gain	☐ nervousness	☐ night sweats	☐ wheezing
☐ pins & needles in arm/legs	☐ numbness in toes/fingers	☐ loss of smell/taste	☐ loss of balance

Gastro-Intestinal

☐ constipation	☐ diarrhea	☐ stomach pain	☐ hemorrhoids
☐ gall bladder/liver problems	☐ nausea	☐ poor appetite	☐ jaundice
☐ rectal bleeding	☐ vomiting	☐ poor digestion	☐ vomiting blood

Eyes/Ears/Nose/Throat

☐ asthma	☐ enlarged thyroid	☐ pain in eyes	☐ poor vision
☐ ear noises	☐ nose bleeds	☐ earache	☐ ear discharge
☐ sore throat	☐ frequent colds	☐ hay fever	☐ sinusitis

Respiratory

☐ chest pain	☐ chronic cough	☐ difficulty breathing	☐ spitting phlegm

Muscles/Joints/Bones

☐ backache	☐ foot problems	☐ pain bet. Shoulders	☐ stiff neck
☐ spinal curvature	☐ swollen joints	☐ twitching	☐ weakness

Cardio-Vascular

☐ ankle swelling	☐ low blood pressure	☐ heart trouble	☐ pain over heart
☐ poor circulation	☐ slow/rapid heart	☐ strokes	☐ high blood pressure

Skin or Allergies

☐ bruise easily	☐ dryness	☐ eczema	☐ hives
☐ sensitive skin	☐ itching		

Women

☐ cramps	☐ hot flashes	☐ irregular cycle	☐ painful periods

List Medications ☐ Check if none	Reason	How Long?	Any Side Effects?
1.____________	____________	______	____________
2.____________	____________	______	____________
3.____________	____________	______	____________

List any broken bones and/or surgeries & date:____________________Year_______ ____________________Year_______

____________________Year_______ ____________________Year_______ ☐ Check if no history of fractures/surgeries

Is there a family history of: ☐ Check if no history

	Heart Disease	Arthritis	Cancer	Diabetes	Kidneys	Other ________
Father's Side	☐	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐	☐

Consent for care:

I, ________________________________(print name) understand that the muscle/massage therapy I receive is 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that muscle therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 muscle therapy 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. I understand that there shall be no liability on the therapist's part including C.A.F.E. of Life Chiropractic, Inc. and Di Carlo Group, LLC and hereby waive, release, discharge and hold harmless C.A.F.E. of Life Chiropractic, Inc. and Di Carlo Group, LLC its members, officers, employees and agents from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the muscle therapy or massage therapy, now or in the future, foreseen or unforeseen. all its employees.

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

______________________________ Signature

______________ Date