CLIENT INTAKE FORM

CONFIDENTIAL Information

Balance in Motion

Please complete all requested information and either email it to erick@balanceinmotionsb.com or present it at your first office visit. I will not be able to perform any therapy without these forms.

Name _____ Date of Birth: _____

Address _____

State _____ City _____ Home Phone _____

Cell Phone _____ May I send a text? ☐

Occupation _____ E-mail Address _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Phone _____

Are you currently taking any medications (including over-the-counter)? ☐ Yes ☐ No

If yes, please list name and reason for medications

Please review this list below for conditions that have ever or are currently affecting your health. Select all conditions that apply and provide an explanation below.

- ☐ Addiction
- ☐ Allergies/Sensitivity
- ☐ Arthritis
- ☐ Autoimmune Dieases
- ☐ Blood Clots
- ☐ Broken/Dislocated Bones
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Circulation Problems
- ☐ Constipation/Diarrhea
- ☐ Diabetes
- ☐ Fibromyalgia/Lupus
- ☐ Hepatitis
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Major Accident
- ☐ Migraine/Headache
- ☐ Neck or Back Problems
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Psychological Conditions
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Sprain/Strain
- ☐ Surgeries
- ☐ Tendonitis/Bursitis
- ☐ TMJ
- ☐ Whiplash

Provide details:

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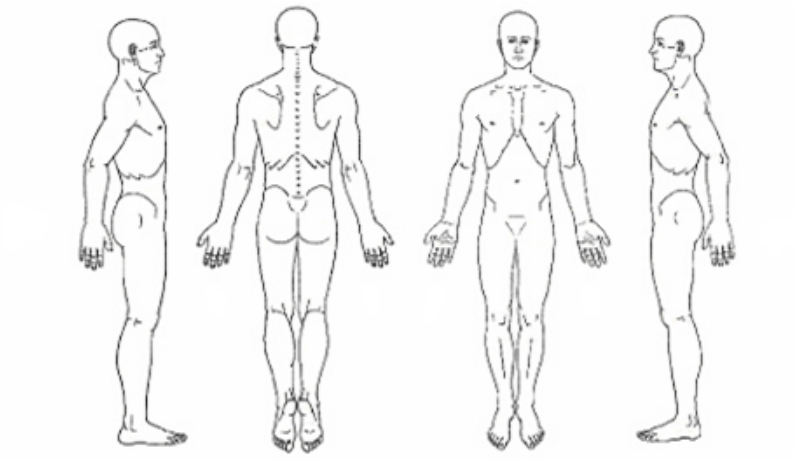
Please indicate with an (x) any areas in which you are feeling discomfort. (Navigate with space bar and enter keys).



What are your goals/expectations for this therapy session?

What is your main complaint? _____

On a scale from 1 to 10, what number is the severity of your main complaint? _____

On a scale from 0-100, what is the percentage of time you experience your main complaint? _____

When do you notice the pain most? ☐ AM ☐ PM

How long does it last? _____

What makes it feel better? _____

What makes it feel worse? _____

Have you ever had this problem in the past? ☐ Yes ☐ No

I have been hospitalized ☐ treated by another chiropractor ☐ treated by another specialty provider ☐ never received care for this problem ☐

Do you have pain/difficulty performing any of these activities?

- ☐ Bending
- ☐ Driving
- ☐ Lifting
- ☐ Reading
- ☐ Personal Care
- ☐ Running
- ☐ Sitting
- ☐ Stretching
- ☐ Sleeping
- ☐ Standing
- ☐ Throwing
- ☐ Walking

Do you currently exercise? _____

What exercise activity? _____

How often do you exercise? _____

Provide Details:

How did you hear of our services?

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CONTRACT FOR CARE

I understand that the therapy provided to me by Erick Hudson is for the purpose of pain reduction, relief from muscle tension, and/or increasing range of motion.

I understand that Erick Hudson does not diagnose illness or disease, prescribe medical treatment or pharmaceuticals, or make spinal manipulations as part of the therapy.

I understand that this therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep Erick Hudson updated on any changes.

Authorizing Signature: _____ Date: _____

PAYMENT

Because of the exclusive and tailored nature of this small business, all clients are asked to give a credit card to hold booked appointments or pay cash/check in advance.

There is a 24-hour notice for cancellation or to reschedule. The credit card will not be billed unless I fail to give the required notice. If I don't give the required notice, the full fee for the session booked will be charged to the my credit card.

I authorize Erick Hudson to effect payment for services at the agreed upon rate to the credit card listed below, should I either cancel my appointment or attempt to reschedule my appointment without 24 hours notice, or not show up for my scheduled appointment. I agree to pay Erick Hudson a $25.00 service fee as a result of not having sufficient funds or credit available in my account. If I discover any unauthorized payments, alterations or other errors in my account, I must notify him within 30 days of when I receive my statement. I agree that if I fail to report any forgeries, alterations, signatures or any other errors to my account within 30 days, I cannot assert a claim against Erick Hudson or Balance in Motion concerning any items in my statement.

Authorizing Signature: _____ Date: _____

Credit Card Number: _____ Exp Date: _____

V-Code _____ Name on Card: _____