DYNAMIC WELLNESS THERAPY
245 West Patrick Street
Frederick, MD 21702

NEW CLIENT INTAKE FORM

CLIENT INFORMATION

Full Name : _____ **Date** : _____

Gender : Female ☐ Male ☐ Nonbinary ☐ Other ☐ _____

Date of Birth: : ____/____/____

Address : _____

Phone Number : ( ) _____ **E-Mail** : _____

☐ Mobile ☐ Home ☐ Other _____

Relationship Status : ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated

Occupation : _____

Client Employer/School: : _____ **Work/School Address** : _____

Employer/School Phone : ( ) _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ YES ☐ NO Date of injury: _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

MANUAL THERAPY HISTORY

Have you ever received professional manual therapy services? ☐ YES ☐ NO

What modalities of manual therapy have you received previously?

☐ Craniosacral Therapy ☐ Visceral Manipulation ☐ Neural Manipulation ☐ Massage Therapy ☐ Other(s) _____

Why did you come for our services?

☐ Pain Management ☐ Improved Mobility ☐ Stress Management ☐ Other(s) _____

What are your goals in seeking manual therapy? _____

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CLIENT HEALTH HISTORY

Please check the box next to any conditions or symptoms you currently have or have had in the past:

- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Breathing Difficulty
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain (TMJ)
- ☐ Lymphedema
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tendonitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors, Growths, Cysts
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Whiplash
- ☐ Other_____

Woman's Health History Only:

Have you ever been pregnant?

☐ YES ☐ NO

Are you currently pregnant?

☐ YES ☐ NO

Number of pregnancies:_____

Number of births:_____

Are you currently using contraception?

☐ YES ☐ NO

If yes, please describe_____

Have you undergone hysterectomy or tubal ligation??

☐ YES ☐ NO

If yes, please provide date:_____

Men's Health History Only:

Have you undergone vasectomy?

☐ YES ☐ NO

If yes, please provide date:_____

Have you undergone vasectomy reversal?

☐ YES ☐ NO

If yes, please provide date:_____

Please list medications you are currently taking: _____

_____

Please list any known allergies: _____

Please list any surgeries, accidents, bone, joint, nerve or muscle diseases or injuries not listed above, including any medical or cosmetic implants, prosthetics, you have received: _____

_____

_____

LIFESTYLE INFORMATION

Exercise:

☐ None ☐ Daily
☐ Moderate ☐ Heavy

Work Activity:

☐ Sitting ☐ Light Labor
☐ Standing ☐ Heavy Labor

Lifestyle:

☐ Smoking Packs/Day_____
☐ Moderate Drinks/Week____
☐ Coffee/Caffeine Cups/Day_____
☐ High Stress Level Reason_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that manual therapy and all of the associated modalites are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that Dynamic Wellness Therapy does not provide diagnose, prescribe or treat any physical or mental illness and is not qualified to perform spinal or skeletal adjustments. I acknowledge that any information that I receive from the therapist(s) at Dynamic Wellness Therapy is educational in nature and is to be used at my own discretion.

_____ _____
Signature of Client, Parent, Guardian or Personal Representative — Date

_____ _____
Printed name of Client, Parent, Guardian or Personal Representative — Relationship to Client

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TREATMENT POLICIES, TERMS & CONDITIONS

Please read through our treatment policies and initial below to indicate understanding.

Session durations:
Session durations begin from your scheduled appointment time and end promptly at your scheduled end time. Please plan to arrive ten minutes prior to your scheduled start time to allow time for parking or use of restroom facilities if needed. Please bring all completed paperwork with you for your first session. Intake forms are required to be completed before treatment can be given.

We are rarely able to extend session durations to accommodate tardy arrivals.

Cancellation Policy:
All appointment cancellations are required no later than 24 hours from the scheduled appointment time to avoid late cancellation fees.

Late Cancellation Fees:

- If appointment is able to be rescheduled within the same calendar week (M-F): No fee.
- 1st late cancellation: 50% of the scheduled visit fee.
- 2nd and subsequent late cancellations: 100% of the scheduled visit fee.

No Show Policy:
No shows are defined as failure to arrive for your scheduled appointment and a failure to communicate with us. No shows are subject to a no show fee of 100% of the scheduled visit fee.

In the event that there is a late cancellation or no show resulting in one of the fees listed above, payment is required at the time of the next visit or within 30 days, whichever occurs first.

I understand and agree to the treatment policies, terms and conditions as described above:

Initials of Client, Parent, Guardian or Personal Representative _____ Date _____

LET US KNOW HOW YOU FOUND US

Please let us know how you heard about us:

☐ Web Search ☐ Social Media ☐ Advertisement ☐ Other _____

☐ Referral from other healthcare provider _____ ☐ Referral from personal acquaintance _____

FINANCIAL RESPONSIBILITY

I understand that Dynamic Wellness Therapy is a private practice and does not participate with private insurance, Medicare or Medicaid. Payment is expected at the time of service. Accepted payment methods include: check, credit card, debit card, HSA card or cash.

I understand that fees for services are subject to change at the discretion of the provider and that I will be provided with a minimum of 30 days advanced notice prior to new rates going into effect.

I understand that as a private practice, I will receive minimal receipt documentation. Additional document requests such as session notes, or detailed receipts for services (including diagnosis or treatment codes) are available only upon request, and for an additional administrative fee (per each request).

I understand that by signing below, I agree to be fully responsible for all fees for services received from Dynamic Wellness Therapy and have specified the financially responsible party below.

Signature of Financially Responsible Party _____ Date _____

Printed name of Financial Responsible Party _____ Relationship to Client _____