WOLF THERAPY

North Boulder Office

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914.486.4616

Manual Therapy Intake Form

Last Name _____ First Name _____ How did you hear about us? _____

Address _____ City _____ State _____ Postal Code _____

Cell Phone _____ Work Phone _____ Emergency Contact _____

Occupation _____ Email _____ Today's Date _____

Birthdate (dd/mm/yr) _____ Sex _____ Pronouns _____ Marital/Partner Status _____

CURRENT SYMPTOMS

*Are you experiencing pain, difficulty breathing, sleep disturbance, etc?

_____

_____

_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Reason for appointment? _____

When did your condition begin? _____

Have you had X-rays, MRI or other tests? _____

Have you ever tested postive for any blood-borne diseases? (Hepatitis C, HIV, etc) _____ ☐ Yes ☐ No

Are you immunocompromised? ☐ Yes ☐ No Are you taking blood thinners? ☐ Yes ☐ No

Is your condition related to: Work? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Motor vehicle accident? ☐ Yes ☐ No Date of injury: _____

Can you perform your daily home activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Can you perform your daily work activities? ☐ All ☐ Only some ☐ Not at all

Describe your stress level: ☐ None ☐ Mild ☐ Moderate ☐ High

Are you, or do plan to become pregnant? ☐ Yes ☐ No ☐ Unknown

Please list any previous surgeries, Illnesses, injuries (motor vehicle accident): _____

Are you receiving care from a Chiropractor, PT, or Osteo? ☐ Yes ☐ No Doctor: _____

Primary Care Doctor _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

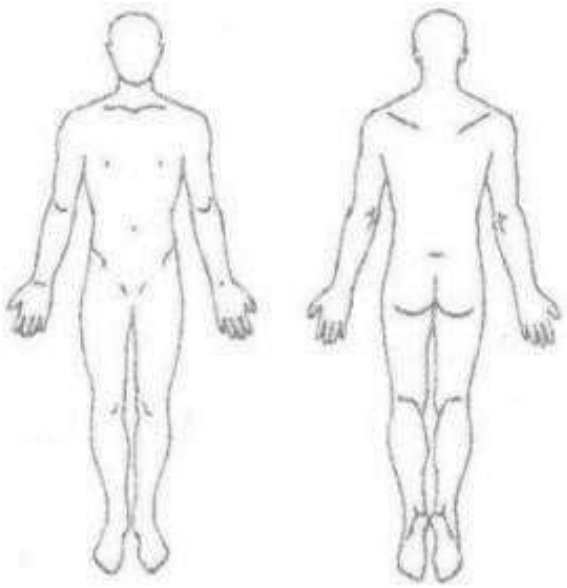
_____

HEALTH HISTORY QUESTIONNAIRE

Have you ever been diagnosed or told you have any of the following?
Please check the correct response:

1. High blood pressure	☐ Yes	☐ No
2. Hardening of the arteries (arteriosclerosis)	☐ Yes	☐ No
3. Diabetes	☐ Yes	☐ No
4. Tuberculosis	☐ Yes	☐ No
5. Cancer, type? _____	☐ Yes	☐ No
6. Heart or blood diseases	☐ Yes	☐ No
7. TBI or concussion	☐ Yes	☐ No
8. Osteoporosis	☐ Yes	☐ No
9. Whiplash injury (flexion-extension injury, cervical sprain)	☐ Yes	☐ No
10. Have you ever suffered a stroke?	☐ Yes	☐ No
11. Were you ever a smoker? From _____ To _____	☐ Yes	☐ No
12. Reproductive health concerns (PMDD, PCOS, HRT, BPH, fibroids, cysts, etc.)	☐ Yes	☐ No
13. Visual disturbances (blurring, loss, double)	☐ Yes	☐ No
14. Hearing disturbances (loss, ringing, other noise)	☐ Yes	☐ No
15. Slurred speech or other speech problems	☐ Yes	☐ No
16. Difficulty swallowing	☐ Yes	☐ No
17. Dizziness	☐ Yes	☐ No
18. Loss of consciousness, even momentary blackouts	☐ Yes	☐ No
19. Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body	☐ Yes	☐ No
20. Sudden collapse without loss of consciousness	☐ Yes	☐ No
21. History of trauma	☐ Yes	☐ No
22. History of anxiety or depression	☐ Yes	☐ No
23. Other _____	☐ Yes	☐ No

Indicate the location of your pain by shading the appropriate area:



Indicate the severity of the pain by selecting a number:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Extreme Pain

Informed Consent for Manual Therapy

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Manual Therapy

I understand that my Licensed Manual Therapist is providing manual therapy services within their scope of practice.

I hereby consent to my Licensed Manual Therapist to treat me with integrative manual therapies for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist.

I acknowledge that my Licensed Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that manual therapy is not a substitute for medical examination or care. It is recommended that I also attend my personal physician for any ailments that I may be experiencing. I understand that treatment outcomes cannot be guaranteed. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that my Licensed Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided and have disclosed all medical conditions affecting me. It is my responsibility to keep my therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I hereby acknowledge that I have discussed with my therapist the assessment of my condition and treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to treatment as proposed to me. I understand that I may withdraw my consent at any time and treatment will be stopped.

_____
INITIALS

What to Wear to Your Appointment

For your session, please wear loose or athletic clothing, such as sweatpants and a comfortable top without a collar or hood. Access to the upper back, neck, and pelvis is important, and restrictive clothing may interfere with the session.

_____
INITIALS

Credit Card Authorization

I, the previously-named authorized credit card user, give Wolf Therapy express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Wolf Therapy. 2) Payment for goods purchased from any practitioner at Wolf Therapy. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges. You may also pay online at booking, or via venmo, or another payment service at your convenience.

_____
INITIALS

**IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.*

_____
INITIALS

Dated this _____day of _____, 20_____.

_____
Name (Please Print)

_____
Patient Signature (or Legal Guardian)

_____
Therapist Signature