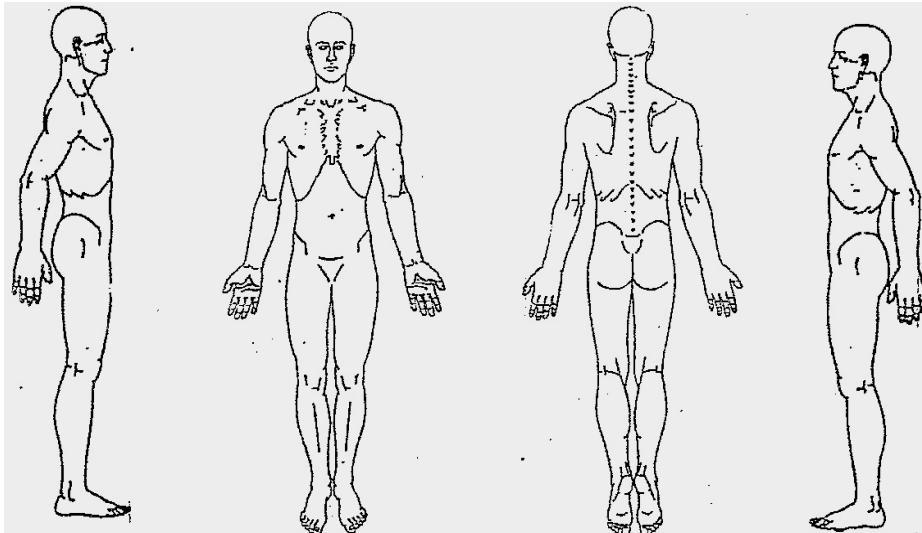


## Client History

PREFIX:		DATE:	
FIRST NAME:		REFERRED BY:	ANOTHER CLIENT?
LAST NAME:		PROFESSIONAL?	
MIDDLE NAME:		GOOGLE ORGANIC:	Y / N
NICKNAME:		GOOGLE ADS:	Y / N
MOBILE N°:		GOOGLE MAPS:	Y / N
NETWORK:		FACEBOOK:	Y / N
HOME N°:		TWITTER:	Y / N
WORK N°:		YELP:	Y / N
EXTENSION:		PINTEREST:	Y / N
ADDRESS:		BLOG:	Y / N
CITY:		<u>EMERGENCY CONTACT</u>	
STATE:		NAME:	
COUNTRY:		RELATIONSHIP:	
ZIP:		PHONE N°:	
E-MAIL:		E-MAIL:	
CHECK THE BOX IF YOU DO NOT WANT TO RECEIVE TEXTS FROM BBW: <input type="checkbox"/>			
D.O.B:		GENDER:	
HEIGHT:		WEIGHT:	OCCUPATION:
Are you pregnant?	Y / N	How many weeks?	
		When is your due date?	Are you a 'high-risk' pregnancy?
			Y / N
Presenting Complaints:			
Goals for treatment:			

Please mark regions of **pain with X's**, mark **P** for "pins & needles" and **N** for "numbness"



**List all surgeries and approximate dates (include cosmetic surgeries):**


**List all motor vehicle and other types of accidents (include approximate dates):**


**List all fractured bones, sprains and major falls:**


**Do you remember any falls on your tailbone? (Think of episodes on snow or ice):**


**List any concussions, head injuries, and brain injuries:**


**List previous medical diagnostic tests and finds (blood chemistry, MRI, etc.) pertinent to presenting complaint(s):**


**List any major illnesses or recurrent illnesses (i.e. Mono. etc.)**


**List previous treatments for presenting complaint(s) and results:**


**List all medications/nutritional supplements you take (include brand name & dosage):**


**Please describe your current activities:**

**Activities:**


**Do you need help making changes to your diet/activities? If so, what changes?**


**Other information you would like to include:**

--

# Your Medical History

Please mark all that apply with an X

- Arthritis
- Allergies/Hayfever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- High blood pressure
- Low blood pressure
- Bronchitis
- Cancer

- Chronic Fatigue
- Carpal Tunnel
- Elevated Cholesterol
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticulitis
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Ear, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux
- Genetic disorder
- Glaucoma
- Gout
- Heart Disease
- Chronic infections
- Kidney disease
- Learning disabilities
- Liver/gall bladder disease
- Mental illness
- Migraine headaches
- Neurologic disease
- Sinus problems
- Stroke
- Thyroid dysfunction
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease

- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

## Female Health

- Menstrual Irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Uteran fibroids
- Ovarian Cysts
- PMS
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Diminished sex drive

Age of 1<sup>st</sup> period \_\_\_\_\_  
Date of last GYN exam \_\_\_\_\_  
Mammogram + \_\_\_ - \_\_\_  
Pap + \_\_\_ - \_\_\_  
Form of birth control \_\_\_\_\_  
# of children \_\_\_\_\_  
# of pregnancies \_\_\_\_\_  
 C-section  
 Hysterectomy  
 Menopause  
Date of last period \_\_\_\_\_  
recent changes in menstrual flow?  
\_\_\_\_\_

## Male Health

- Benign prostate hyperplasia
- Prostate cancer
- Diminished sex drive
- Infertility
- Other \_\_\_\_\_

## Family Health History

- Arthritis, rheumatoid
- Arthritis, osteoarthritis
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorders
- Genetic disorders
- Glaucoma
- Heart disease
- Infertility
- Mental illness
- Migraine headaches
- Neurologic disorder
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_
- Other \_\_\_\_\_

## Health Habits

- Tobacco
- # cigarettes per day \_\_\_\_\_
- Alcohol
- Wine: glasses per day/wk \_\_\_\_\_
- Beer: # per day/wk \_\_\_\_\_
- Liquor: oz. per day/wk \_\_\_\_\_
- Caffeine
- Coffee: #6oz cups per day \_\_\_\_\_
- Espresso: #oz per day \_\_\_\_\_
- Tea: #6oz cups per day \_\_\_\_\_
- Soda: #cans per day \_\_\_\_\_
- Water
- # of glasses per day \_\_\_\_\_

**Exercise**

- 1-2 days/wk
- 3-4 days/wk
- 5-7 days/wk
- 45+ min/workout
- 30-45min/workout
- <30min/workout
- Walk
- Run, jog, jump rope
- Weight lifting
- Swim
- Martial arts
- Yoga
- Pilates
- Tai Chi
- Cycling
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**Diet**

- Omnivore (meat & vegetables)
- Vegetarian (vegetarian + milk/eggs)
- Vegan (vegetarian & NO eggs/ milk)
- Salt restriction
- Fat restriction
- High Carbohydrate diet
- Calorie restriction

**Known Food Sensitivities**

- Dairy
- Wheat
- Eggs
- Citrus
- Soy
- Corn
- Nuts
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**Food Frequency**

\*\*\* servings per day

- Fruit
- Vegetables
- Cooked grains
- Beans
- Dairy
- Eggs
- Meat, poultry, fish
- Water

**Eating Habits**

- Three meals/day
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

**Do you consider yourself**

- Underweight
- Overweight
- Ideal weight
- Unintentional weight loss/gain lately
- Your weight today

**Do you experience any of these general symptoms daily?**

- Fatigue
- Depression
- Disinterest in sex
- Disinterest in eating
- Shortness or breath
- Panic attacks
- Headaches
- Dizziness
- Insomnia
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Urinary incontinence
- Fecal incontinence
- Low grade fever
- Chronic pain/inflammation
- Bleeding
- Mucous or pus discharge
- Itching/Rash

**Is your job associates with**

- Extensive stress
- Harmful chemicals
- Repetitive movement
- Heavy lifting
- Life threatening activities (e.g. firefighter)

**Sleep Habits**

- Sleep well-no problems
- Sleep disturbance-mild
- Sleep disturbance-moderate
- Sleep disturbance-extreme
- Sleep apnea
- Awaken to urinate
- Recent changes in sleep
- Awaken same time each night at \_\_\_\_\_ a.m./p.m.
- Use medication to sleep

Generally sleep \_\_\_\_\_ hrs/night

**Your primary treatment goals are**

- Pain relief
- More energy
- Improved digestion
- Increased strength
- Increased sex drive
- Improved skin, hair, nails
- Improved moods
- Improved brain function
- Headache relief
- Improved range of motion
- Improved sleep
- Allergy relief
- General wellness
- Lower risk of disease
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_



**On-Time Policy for  
Traditional Osteopathic Manual Therapy**

We know that your time is valuable. As such, we do our best to maintain a punctual schedule. Please be aware, the practices of Comprehensive and Orthopedic Manual Therapies are not a linear, therefore a practitioner may run late. We ask you to be on time for your scheduled appointment, but we also ask for your patience when a practitioner is running behind.

We do our best to call ahead and give you advanced notice if we know a practitioner will be 15 minutes or more behind schedule, but this is not always possible. We strongly recommend that you do not schedule other appointments immediately following your appointment as we will not issue a partial or total refund if you cannot stay for the completion of your appointment. Please sign below to indicate that you have read and understand this policy.

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

**Cancellation List Policy for  
Comprehensive Manual Therapy with David Schwartz &  
Orthopedic Manual Therapy with Elizabeth McClain**

Should you be added to the cancellation list, please ensure you give us the best number at which to reach you and inform us of preferred and unavailable dates. Openings are entirely dependent on whether another client cancels an appointment. Should we contact you, please respond as soon as possible. *BoulderBodyworks* will call everyone on the cancellation list for each available appointment. The first person to answer or respond will be booked.

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



### Waitlist Policy

*The waitlist policy applies to all classes and appointments except for Comprehensive Manual Therapy with David Schwartz and Orthopedic Manual Therapy with Elizabeth McClain.*

**If an appointment or space in class becomes available with greater than 24 hours' notice** in accordance with your waitlist request, the appointment or class will automatically be booked and you will receive a confirmation of the booking. The cancellation policy will apply to that booking.

**If an appointment becomes available with less than 24 hours' notice or after 12pm on a Saturday for a Monday, BBW** will contact all clients on the waitlist with the opening. The first to confirm will be scheduled.

Should you no longer be available for an appointment or class that you requested, it is your responsibility to cancel the reservation in accordance with the cancellation policy:

### Cancellation Policy

*BoulderBodyworks* requires a full **24 hours' notice** for any cancellations, schedule changes or 'no-shows'. You will be charged the full fee if you miss or change your scheduled appointment with less than 24 hours' notice. We understand that situations, such as medical emergencies, may arise and therefore adequate notice may not be possible. These situations will be considered on a case-by-case basis.

*BoulderBodyworks* is closed on **Sundays**. Any cancellations or schedule changes for Monday must be completed by noon on Saturday. Any changes made later than noon on Saturday will be subject to charge.

By signing this cancellation policy:

I \_\_\_\_\_ (print your name) agree to pay all charges that are a direct result of my missing or canceling an appointment without appropriate notice. I understand that the credit card on file will be charged for the full amount no earlier than 48-hours after my missed or late cancelled appointment. If I would like to use a different method of payment, I understand that it is my responsibility to contact *BoulderBodyworks* prior to the 48-hour time frame to provide my preferred method of payment.

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