New Client Intake & Health History Form

Name: ____

Address:____

City/State/Zip:____

Phone
Number:____

Email
Address:____

Occupation: ____

Emergency Contact
Name/Number:____

On a scale of 1-10 (10 being the highest), how would you rate your level of daily activity? ____

On a scale of 1-10 (10 being the highest), how would you rate your level of daily stress? ____
What are your current health/wellness goals? (Check all that apply)

____ Weight Loss/Maintenance
____ Strength Building
____ Stress Relief
____ Flexibility
____ Balance/Inner Peace
____ Improve Overall Health
____ Optimism/Life
____ Alternative Therapy (explain below)
____ Address Specific Health Concern (explain below)
____ Other (explain below)

Other/Explain More:
____
____
____

Please review the following list and check any health conditions that apply to you or have applied to you within the past 3 years.

____ Arthritis
____ Osteoporosis
____ Muscle Pain
____ Muscle Weakness
____ Scoliosis
____ Bulging Disc
____ Degenerative Disc
____ Back Pain/Injury
____ Anemia
____ Sciatic
____ Diabetes
____ Asthma/Shortness of Breath
____ Seizures
____ Stroke
____ Heart Conditions/Chest Pain
____ Anxiety
____ Depression
____ High Blood Pressure

____ Low Blood Pressure
____ Surgery (explain below)
____ Knee Pain/Injury

____ Cancer (explain below)
____ Pregnant (explain below and estimated due date)

Other/Explain More:
____
____
____

Are you currently taking any medications? ____ Yes ____ No

If so, please list the names and their purpose:
____
____
____
____
____
____
____
____
____

I authorize the collection and use of the above personal information as is required for therapeutic treatment and related administrative purpose. I understand that all my personal information is confidential and will not be released without my signed consent.

I understand that any service received by Attract Balance is not a substitute for medical attention, examination, diagnosis or treatment. Certain activities are not recommended and are not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in the classes offered by Attract Balance. In addition, I will make my instructor aware of any medical condition or physical limitations before class. If I am pregnant, become pregnant or I am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I also affirm that I alone am responsible to decide whether to practice and participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against Attract Balance.

If client is under the age of 18, a parent or guardian must sign.

Printed Name: ___________________________________Date: ______________________

Signature: ____