Jacqueline Faulkner, Manual Therapy

1870 46th Ave

Capitola, Ca 95010

831 345-9955 / 831 476-5913

Client Intake Form

Date _____

Name _____ Age _____

Address_____

Street and Number City State Zip

Date of Birth _____

Cell Phone #_____ Home # _____ Business # _____

E-Mail_____

Current Occupation_____

Emergency Contact _____Relationship_____ Phone_____

Referred by _____

List your primary health concerns and rate on a scale from 1-10 on how much they impact your life

(0= no impact)

1._____

2._____

3._____

4._____

Other practitioners (acupuncturist, chiropractor, osteopath, naturopath, etc.) you are currently seeing

_____

_____

_____

List any major hospitalizations and/or surgeries you have had (include year)

_____

_____

_____

_____

_____

_____

List any major illnesses you have had (include year)

_____

_____

_____

_____

_____

List any scar tissue. fractures, dislocations or concussions you have had (include year)

_____

_____

_____

_____

_____

_____

List any motor vehicle accidents, falls, injuries or accidents you have had (include year)

_____

_____

_____

_____

_____

_____

Medications

What medications are you currently taking?

Medications _____For What _____For how long_____

_____

_____

_____

_____

_____

_____

List any over the counter medications and/or supplements you are currently taking

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

Current	Past		
○	○	Smoking	Packs per day/ number of years_____
○	○	Coffee	Cups per day _____
○	○	Alcohol	Quantity_____
○	○	Antacids	
○	○	Steroids	
○	○	Analgesics	
○	○	Laxatives	

Review of Systems

Current	Past	**CranioSacral:**
◯	◯	Headaches
◯	◯	Migraines
◯	◯	Concussions
◯	◯	Fall on Tailbone
◯	◯	Fall on Sacrum or hips
◯	◯	Major dental work
◯	◯	Braces
◯	◯	Sinusitis
◯	◯	Facial pain
◯	◯	Congestion
◯	◯	Ear infections
◯	◯	Hearing loss
◯	◯	Other:
		_____
		_____

Digestion

◯	◯	Heartburn
◯	◯	Constipation
◯	◯	Diarrhea
◯	◯	Nausea
◯	◯	Gas
◯	◯	Pain after eating
◯	◯	IBS
◯	◯	Hiatal Hernia
◯	◯	Food sensitivities:
		_____
		_____
◯	◯	Other:
		_____
		_____

Heart

◯	◯	Arrhythmia
◯	◯	Palpitations
◯	◯	High Blood Pressure
◯	◯	Heart attack
◯	◯	Other:
		_____
		_____

Current	Past	**Urinary Tract:**
◯	◯	Kidney infections
◯	◯	Bladder infections
◯	◯	Frequency of urination
◯	◯	Loss of bladder control
◯	◯	Kidney stones
◯	◯	Prostate problems (men)
◯	◯	Changes in urinary flow
◯	◯	Other:
		_____
		_____

Lungs

◯	◯	Bronchitis
◯	◯	Pneumonia
◯	◯	Coughing
◯	◯	Difficulty breathing
◯	◯	Asthma
◯	◯	Other:
		_____
		_____

Liver

◯	◯	Hepatitis
◯	◯	Mononucleosis
◯	◯	Elevated liver enzymes
◯	◯	Fatty Liver Syndrome
◯	◯	Other:
		_____
		_____

Other

◯	◯	Hyperthyroid
◯	◯	Hypothyroid
◯	◯	Autoimmune Disorders
◯	◯	Diabetes
◯	◯	Arthritis
◯	◯	Osteoporosis
◯	◯	Cancer
◯	◯	Stroke
◯	◯	Joint Issues
◯	◯	Other:
		_____
		_____

Sleep
Hours per night_____
If you wake, what is the reason? _____ at what time? _____
Nightmares_____ Must nap during day _____ Wake refreshed _____
Sleep apnea _____ Hours using CPAP during night _____

Stress
Choose from the following: 0= never 1= almost never 2= sometimes 3= fairly often 4= very often
In the last month, how often have you felt nervous and/or stressed _____
In the last month, how often have you been upset because of something happening unexpectedly? _____
In the last month, how often have you found you could not cope with all the things that you have to do?
_____
Do your symptoms increase when you are under stress? _____

Diet
On a scale of 1 to 10 (1 being extremely poor, 10 being extremely healthy) how would you rate your diet
_____
Describe a typical Breakfast _____
Describe a typical Lunch _____
Describe a typical Dinner _____
How often do you snack in between meals? _____

Exercise
How often do you exercise? _____
What type of exercise? _____
For how long? _____

Gynecologic History (Women only)
Cycle Length _____
Pregnancies _____ Births _____ Miscarriages _____

Current	**Past**	
◯	◯	Cramping
◯	◯	Pain during menstruation
◯	◯	Pain during ovulation
◯	◯	Cysts
◯	◯	Endometriosis
◯	◯	Menopause
◯	◯	Other:

_____

Any other information you feel is important to share
_____
_____
_____

Client Acknowledgement and Consent to Receive Services:

- I understand that cash, check or credit card are accepted for payment. If I am paying by check, I will have my check made out in advance of my session. This will allow time at the end of the session for me to book all future appointments.

- I agree to dress in comfortable clothing.

    - Loose fitting pants and collarless shirts (T-shirts) are best. This would include clothing such as gym and yoga type clothing. **No jeans please,** as the seams are too thick and uncomfortable to work on, both for you and for me.

- If I have questions that arise between sessions, I understand that I am free to contact Jacqueline Faulkner, Manual Therapist. I understand that she will return my call as soon as she is able.

    - (Please leave me times that are best for reaching you. You can also text me at 831 345-9955 or email me at **lighttouch@baymoon.com.)**

- To maintain a hypoallergenic environment, I agree to refrain from wearing perfume or fragranced body and/or hair products prior to my appointment.

- I have consented to use the services offered by Jacqueline Faulkner, Manual Therapist, and agree to be personally responsible at the time of service for the fees in connection with the services provide to me.

- I understand that Jacqueline Faulkner works by appointment and that a **48-hour notice** is required to cancel or reschedule an appointment. If I am unable to provide a 48-hour notice I agree to pay the full fee for the treatment time reserved. (Substitutions are permissible as available)

I have read and understand the above client agreement in regard to the therapy offered by Jacqueline Faulkner.

Signed:_____ Date:_____

(Client/parent/guardian)

Indicate relationship if signing for someone else: _____

Precautionary Coronavirus Protocols

Due to the outbreak of the novel Coronavirus, COVID-19, I am taking extra precautions in working with each client to provide the greatest level of safety I possibly can. I have instituted several procedures to ensure everyone's safety. I ask that each of you please follow these protocols for each of your appointments:

- Please wear clean clothes and a clean mask to your appointment
- Please wait in your car until your appointment time. I will call you on your cell phone when I am ready for you. Make sure I have your current cell phone number.
- If you have someone with you, they will have to wait in the car. For the time being, I cannot use my living room as a waiting room.
- I will be taking everyone's temperature at the door.
- I ask that you go straight through to the bathroom and wash your hands for the recommended 20 seconds and then go into the treatment room.
- For the time being, I will not be using a blanket so please dress accordingly for your comfort level

All massage table linens are changed after each client and clean linens are then put onto the table.
I am cleaning, disinfecting and sanitizing the treatment room and the bathroom after each client.
For your protection I will also be wearing a mask. If you feel a need for more protection, let me know and I will be glad to accommodate you with my wearing gloves and/or a face shield.

Precautionary Coronavirus Liability Release Form

I understand and affirm that I, as well as all my household members, do not currently have, nor have experienced the symptoms of COVID-19 within the last 14 days.
I affirm that I, as well as all my household members, have not knowingly been diagnosed with COVID-19 within the last 14 days.
I affirm that I, as well as all my household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 14 days.
I affirm that I, as well as all my household members, have not traveled outside of the country or to any city or county outside of our own that is or has been considered a "hot spot" for COVID-19 infections within the last 14 days.
I understand that this business and my Manual Therapist, Jacqueline Faulkner, cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.
By signing below, I agree to each of the above statements and release Jacqueline Faulkner, Manual Therapist, and this business, from any and all liability for the unintentional exposure or harm due to COVID-19.

Client Signature:_____ Date:_____

I, Jacqueline Faulkner, Manual Therapist, agree that I abide by these same standards and affirm the same. I also affirm that I have improved and expanded my sanitization protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.