Cerise M. LaCore, Bsc., CMT
Certified Traditional Japanese Reiki Shihan
Teaching Traditional Japanese Reiki since 1997
Phone: 916-956-2181
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Client Health Intake Form

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth (mm/dd/yy): _____/_____/_____.

Home Phone: _(____)_____ Cell Phone: __(____)_____

E-mail:_____

Emergency Contact Person: _____ Phone: _(____)_____

Occupation: _____ Work Phone: __(____)_____

Are you currently under a physicians care for an acute or chronic illness? Y ___ N ___

If yes please explain: _____

If yes, name/address of health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? Y __ N __

If yes please explain: _____

Have you received an Ortho-Bionomy® session before? Y___ N___ If yes, when: _____

How did you hear about us? _____

What are your goals for this session: _____

Please list areas of tension, stress and/or pain you wish to be addressed: _____

_____

Health Information - *Please mark an (X) by all current conditions and (P) for all past conditions:*

__ Abdominal /digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or lung condition.
__ Athletes foot
__ Blood clots
__ Chronic pain
__ Circulatory/heart problems
__ Constipation/diarrhea
__ Depression
__ Diabetes
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ High blood pressure
__ Jaw pain/TMJ pain
__ Low blood pressure
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pregnancy
__ Rash/fungus
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Vision problems
__Varicose veins
__ Other:_____
_____

Elaborate on areas noted on previous page: _____

_____

List recent injuries or surgeries within the past 15 years: _____

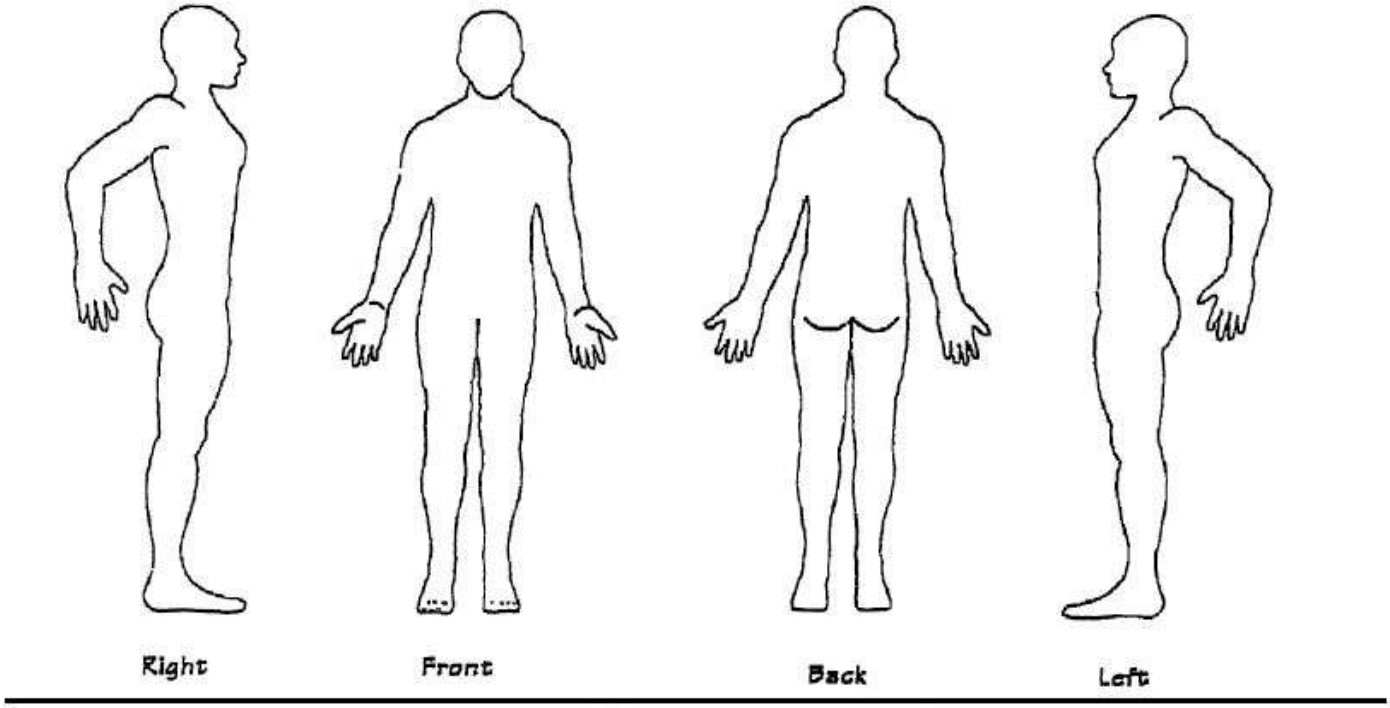
_____

List stress-reduction activities, hobbies, exercise and/or sport participation: _____

_____

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and therapist if anything changes in my status. I understand that Ortho-Bionomy® is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that Ortho-Bionomy® is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving an Ortho-Bionomy® session at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid Ortho-Bionomy® session, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: _____ Date: _____

Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

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PRIVATE PAY OFFICE POLICY &

MISSED APPOINTMENT AGREEMENT

Payment for each office visit is due and collected at the time of service.

I understand that if I am sent to collections for an outstanding bill, I will be responsible for any and all applicable collection fees, court costs and attorney fees which are incurred as a result of this action.

In addition, I understand that there will be a $125.00 charge for any missed appointments without giving 24-hour notice. also understand that I will be held responsible for payment and that my insurance company *(if any*) will not pay for a missed appointment charge.

_____

Clients Name (please print)

_____ _____

Clients Signature Date