Peggy Thompson-Rhodes, L.M.T.
(License 4082)*

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CONFIDENTIAL CLIENT INFORMATION

Please take time to fill out this intake form so that we may best serve your needs. All information is kept strictly confidential.

Name_____DOB_____

Mailing Address_____

City_____State_____Zip_____

Email_____Phone_____

Parent/Guardian if under 18_____

Occupation_____Employer_____

Physician_____Phone_____

Emergency contact:

Name_____Phone_____Relation_____

How did you find out about Rivers of Health? _____

Please list your main reasons for seeking treatment. _____

_____

_____

Please describe you pain. _____

_____

What makes it worse? _____

_____

_____

What makes it better? _____

_____

Are there any other symptoms you have been having (whether or not you consider them a priority)? _____

_____

Have you consulted a physician about any of the above mentioned? If so is there a diagnosis? _____

_____

What movements and or positions are difficult for you? _____

_____

What are your goals for therapeutic intervention (I know I'm getting better…)? Please be specific (something we can look back on as a measure of progress). _____

_____

Please summarize your medical history including surgeries, injuries, chronic problems/conditions, loss of consciousness or any condition requiring long-term medication. _____

_____

_____

_____

_____

Please list medications and supplements you are taking and what you take them for.

_____

_____

_____

Please check all that apply to you:

Headaches___
Stiffness___
Unusual fatigue___
Dizziness___
Depression___
Eye pain/pressure___
Ear pain/ringing___
Anxiety___
Memory Loss___
Coordination Problems___
Poor Attention Span___
Tingling___
Allergies___
Sinus Problems___

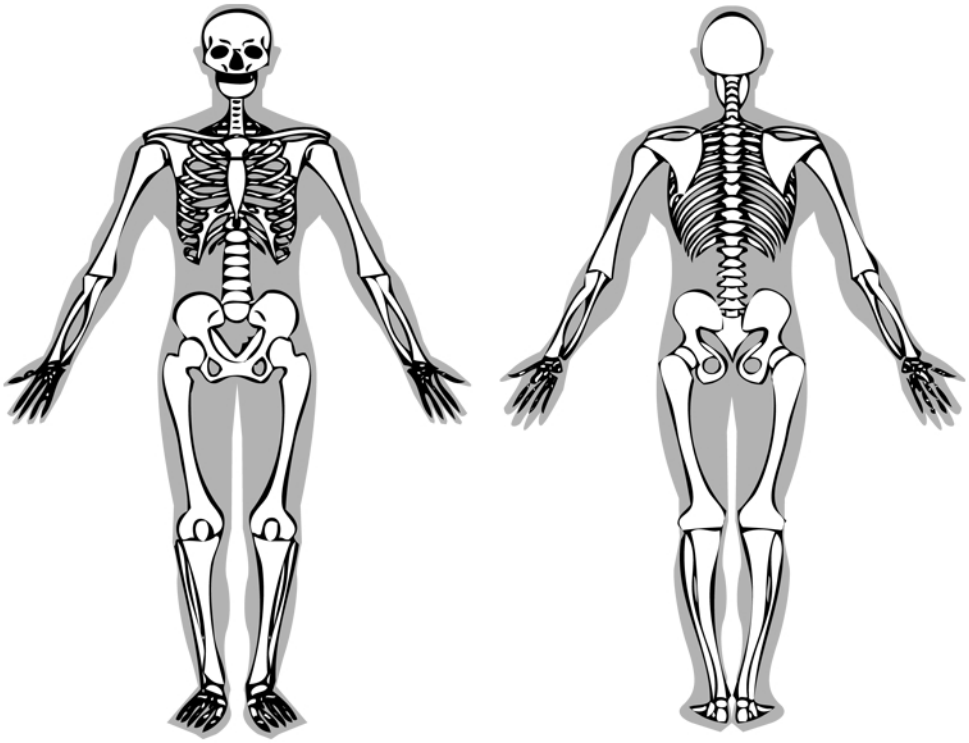
Weakness___
Restlessness___
Indigestion/Reflux___
Chest pain___
Sleeping problems___
Bladder problems___
Neck, Face, Jaw pain___
Bowel Problems___
Decreased Concentration___
Balance Problems___
Numbness___
Shortness of Breath___
Chronic Soreness___
Nausea___

CC

Can you think of any emotional traumas or significant stressors you have had, recent or past? _____

_____

Pain diagram: Please shade in areas related to your problems(s) and please label pain, numbness, tingling, or other symptoms you experience.



I understand that the purpose of the treatment I receive at Rivers of Health is to support my body's own corrective ability. This purpose is accomplished through manipulation and education; both experiential and cognitive.

I recognize that I am a participant in a process, not a patient in a medical procedure, and that my awareness and internal experience are a necessary part of the process. I agree to participate in this process as fully as I am able. I understand the treatment I receive at Rivers of Health is not involved with the treatment of disease and not a substitute for medical diagnosis or treatment when such attention is needed.

I understand that it is necessary for a manual therapist to touch my body in order to assist me in establishing balance and correction. I give Peggy Thompson-Rhodes my permission and consent to work on my body in such a way as to restore balance and correction therein.

Insurance Billing: I do hereby authorize above mentioned therapist to furnish my insurance company with a full report of her examination, treatment and prognosis of myself in regard to any accident in which I am involved.

I hereby authorize and direct my insurance company to pay directly to said therapist such sums as may be due and owing her for therapy service rendered me by reason of this accident and by reason of any other bills that are due her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said therapist. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Cancellation: I understand that sessions missed or cancelled with less than 24 hours' notice may be subject to charges for time lost.

I have read and understood the above statements.

Signed_____ Date_____