Client Intake Form

Name: ____ Date: ____________________

If minor: Parent / Guardian: ____________________________________ Date of Birth: ________________

Address: ____

City: ____ State: _______ Zip: _____________

Home Phone #: ______________________________ Work Phone #: ______________________________

Cell Phone #______________________________ Email Address: _________________________________

Sex: ❑ Male ❑ Female:

Are you comfortable being treated by a staff member of the opposite gender? ❑ Yes ❑ No

In Case of Emergency, Please Notify: Name: ____

Telephone #: ________________________ Relationship: ____

How did you hear about Omni Physical Therapy?

❑ Physician ❑ Family/Friend ❑ Advertisement/Online ❑ Insurance

IMPORTANT: RELEASE AND WAIVER OF LIABILITY AND INDEMNITY. You acknowledge that I take full responsibility for all activities in which I participate at Omni Physical Therapy LLC. I hereby acknowledge and agree that use of Omni Physical Therapy LLC facilities, services, equipment or premises involves risks of injury to persons and I assume full responsibility for such risks. I hereby release and hold Omni Physical Therapy LLC free from all liability for any loss or damage, and forever give up any claim or demands therefore, on account of injury to person or property, including injury leading to the death, whether caused by the active or passive negligence of Omni Physical Therapy LLC or otherwise, to the fullest extent permitted by law, while upon, or about Omni Physical Therapy LLC premises or using any Omni Physical Therapy LLC facilities, services or equipment. By signing above, I acknowledge that I have read and understand this Waiver of Liability.

***The therapist reserves the right to refuse service to anyone at any time for any reason.**

SIGNATURE: ____ **Witness** __________ **Date**_________

Patient or parent/guardian of minor child

Informed Consent

I am informed and understand that there are risks that come with any wellness therapy program. I affirm that I have not withheld any information that may be relevant to my safe participation in this wellness therapy program. I release Omni Physical Therapy and staff from any liability related to any injury sustained while performing any exercises performed under the supervision or otherwise while at Omni Physical Therapy or otherwise.

SIGNATURE: ____ Witness __________ Date_________

Patient or parent/guardian of minor child

Cancellation Policy

We understand that unanticipated events happen occasionally and you may need to cancel an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

- 24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.

- If you are unable to give us 24 hours advance notice you will be charged the full amount of your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment and future service will be denied until payment is made.

Arriving late

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time.

I have read and understand the terms of the cancellation policy stated above.

SIGNATURE: ____ Witness __________ Date_________

Patient or parent/guardian of minor child

Omni Physical Therapy
Your All Inclusive Manual Therapy Provider

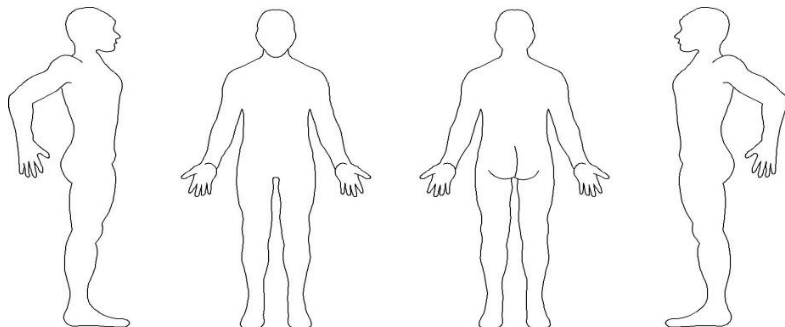
PAST MEDICAL HISTORY

Please mark an (X) for and conditions that apply now and a (P) for any past conditions.

- ☐ Headaches
- ☐ Hearing or Vision Problems
- ☐ Injuries to face or head
- ☐ Sinus Problems
- ☐ Jaw Pain, TMJD
- ☐ Sprains of Strains
- ☐ Asthma
- ☐ Arthritis, Tendonitis
- ☐ Constipation, Diarrhea
- ☐ Depression
- ☐ Spinal Column Disorders
- ☐ Chronic Pain
- ☐ Muscle or Joint pain
- ☐ Heart, Circulatory Problems
- ☐ Bursitis
- ☐ Tension Stress
- ☐ Sleep Difficulties
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Allergies, Sensitivities
- ☐ Rashes, Athletes Foot
- ☐ Hypo/Hyper Thyroid
- ☐ Diabetes
- ☐ Muscles or bone injuries
- ☐ Numbness or Tingling
- ☐ Fibromyalgia
- ☐ Fatigue
- ☐ Cancer, Tumors
- ☐ Pregnancy
- ☐ High/Low Blood Pressure
- ☐ Other

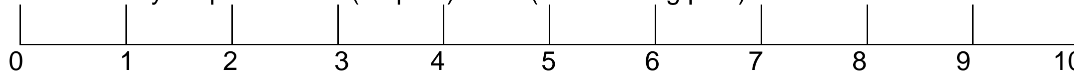
Body Assessment

Please identify current problem areas by drawing the appropriate symbols on the diagrams below.



Symbols
O = Circle areas where pain exists
∭ = Stiff areas
● = Area of tenderness
X = Area of tightness

Please rate your pain from 0 (no pain) to 10 (excruciating pain).



0 1 2 3 4 5 6 7 8 9 10

Comments or Concerns: ____
____
____
____

SIGNATURE: ____ **Date**_________

Patient or parent/guardian of minor child

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