*Manual Therapy NYC*

*Delia Ahouandjinou LMT, CST*

*CranioSacral Therapy*

*Visceral Manipulation*

*Reiki*

32 Union Square East*, # 612*

*New York, NY 10003*

*1-646.417.1837*

*www.manualtherapynyc.com*

**Manual Therapy NYC Intake Form**

***Personal Information***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Sex : \_\_\_\_\_Male \_\_\_\_\_Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please notify:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for this session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Health Information***

Are you currently under a physician care for an acute or chronic illness? \_\_\_\_ No \_\_\_ Yes

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any infectious disease? \_\_\_\_ N \_\_\_\_ Y

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any prescribed medication, over the counter medication, dietary supplements, vitamins or herbs? \_\_\_ No \_\_ Yes. If yes please list names and reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you wearing contact lenses? \_\_\_ Dentures? \_\_\_ Hearing aid? \_\_\_\_ Pacemaker?

\_\_\_\_ Transdermal patch? \_\_\_\_ Catheter?

Do you experience stress in your work, family, or other aspect of your life? \_\_\_ No \_\_\_ Yes

Do you have children? Age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how do you think it has affected your health?

Muscle tension \_\_\_\_\_\_\_ Anxiety \_\_\_\_ Insomnia \_\_\_\_ Irritability \_\_\_\_ Sadness \_\_\_\_\_\_\_\_\_

Issue Concentration \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Family History***

Please check any occurrence of the following in your family’s history.

\_\_\_ Heart Disease

\_\_\_ Diabetes

\_\_\_ Arthritis

\_\_\_ Cancer

\_\_\_ Osteoporosis

\_\_\_ Alzheimer’s

\_\_\_ Mental Illness

\_\_\_ Thyroid condition

\_\_\_ Liver condition

\_\_\_ Kidney condition

\_\_\_ Respiratory

disease

Check the following conditions that apply to you, **past and present**. Add your comments to clarify the condition. Please use back of form to explain all checked conditions.

***Musculo-Skeletal***

Do you have any difficulty lying on your front, back, or side? \_\_\_\_ No \_\_\_\_ Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sit for long hours at a workstation, computer, or driving? \_\_\_\_ No \_\_\_\_Yes

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

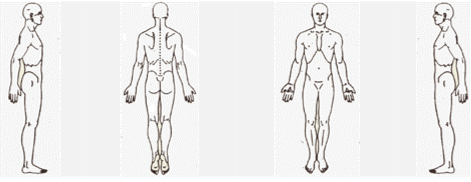
Do you perform any repetitive movement in your work, sports, or hobby? \_\_\_ No \_\_\_\_ Yes

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a particular area of the body where you are experiencing tension, stiffness, pain?

or other discomfort? \_\_\_\_ No \_\_\_\_ Yes

If yes, please identify: indicate with an (X) the areas in which you are feeling discomfort:



\_\_\_ Headaches

\_\_\_ Joint stiffness/swelling

\_\_\_\_Spasms/cramps

\_\_\_\_ Broken/fractured bones

\_\_\_\_ Strains/sprains

\_\_\_\_ Back, hip pain

\_\_\_\_ Shoulder, neck, arm, hand pain

\_\_\_\_ Leg, foot pain

\_\_\_\_ Chest, ribs, abdominal pain

\_\_\_\_ Problems walking

\_\_\_\_ Jaw pain/TMJ

\_\_\_\_ Tendonitis

\_\_\_\_ Bursitis

\_\_\_\_ Arthritis

\_\_\_\_ Osteoporosis

\_\_\_\_ Scoliosis

\_\_\_\_ Bone or joint disease

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Circulatory and Respiratory***

\_\_\_\_ Anemia

\_\_\_\_ Shortness of breath

\_\_\_\_ Dizziness / Fainting

\_\_\_\_ Cold feet or hands

\_\_\_\_ Cold sweats

\_\_\_\_ Swollen ankles

\_\_\_\_ Varicose veins

\_\_\_\_ Blood clots

\_\_\_\_ Stroke

\_\_\_\_ Heart condition

\_\_\_\_ Allergies

\_\_\_\_ Sinus problems

\_\_\_\_ Asthma

\_\_\_\_ High blood pressure

\_\_\_\_ Low blood pressure

\_\_\_\_ Lymphedema

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Skin***

Do you have any allergies to oils, lotions, or ointments? \_\_\_\_ No \_\_\_\_Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sensitive skin? \_\_\_\_ No \_\_\_\_Yes

\_\_\_\_ Rashes

\_\_\_\_ Allergies

\_\_\_\_ Athlete’s Foot

\_\_\_\_ Warts

\_\_\_\_ Moles

\_\_\_\_ Acne

\_\_\_\_ Cosmetic surgery

\_\_\_\_ Decubitus Ulcer

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Digestive***

\_\_\_\_ Nervous stomach

\_\_\_\_ Indigestion

\_\_\_\_ Constipation

\_\_\_\_ Intestinal gas/bloating

\_\_\_\_ Diarrhea

\_\_\_\_ Diverticulitis

\_\_\_\_ Irritable bowel syndrome

\_\_\_\_ Crohn’s Disease

\_\_\_\_ Colitis

\_\_\_\_ Adaptive aids

\_\_\_\_ Hepatitis / Jaundice

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Nervous System***

\_\_\_\_ Numbness/tingling

\_\_\_\_ Twitching of face

\_\_\_\_ Fatigue

\_\_\_\_ Chronic pain

\_\_\_\_ Sleep disorders

\_\_\_\_ Ulcers

\_\_\_\_ Paralysis

\_\_\_\_ Herpes/shingles

\_\_\_\_ Cerebral Palsy

\_\_\_\_ Epilepsy

\_\_\_\_ Chronic Fatigue Syndrome

\_\_\_\_ Multiple Sclerosis

\_\_\_\_ Muscular Dystrophy

\_\_\_\_ Radiculopathy

\_\_\_\_ Spinal cord injury

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Reproductive System***

Pregnancy:

\_\_\_\_ Current

\_\_\_\_ Previous

\_\_\_\_ PMS

\_\_\_\_ Menopause

\_\_\_\_ Pelvic Inflammatory Disease

\_\_\_\_ Endometriosis

\_\_\_\_ Hysterectomy

\_\_\_\_ Fertility concerns

\_\_\_\_ Prostate problems

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Other***

\_\_\_\_ Loss of appetite

\_\_\_\_ Forgetfulness

\_\_\_\_ Depression

\_\_\_\_ Difficulty concentrating

\_\_\_\_ Drug use

\_\_\_\_ Alcohol use

\_\_\_\_ Nicotine use

\_\_\_\_ Caffeine use

\_\_\_\_ Hearing impaired

\_\_\_\_ Visually impaired

\_\_\_\_ Burning upon urination

\_\_\_\_ Bladder infection

\_\_\_\_ Eating disorder

\_\_\_\_ Diabetes

\_\_\_\_ Fibromyalgia

\_\_\_\_ Post/Polio Syndrome

\_\_\_\_ Cancer

Other congenital or acquired disabilities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries \_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (client) have completed the form to the

best of my knowledge and I shall take it upon myself to inform the therapist of any changes.

I understand that Delia Ahouandjinou LMT, CST, does not diagnose illness or disease or other medical, physical or emotional disorder, nor prescribe any medications/treatments. I acknowledge that I am responsible for consulting a qualified physician for any ailments that I may have. If necessary, I allow Delia to discuss with my health care provider the appropriateness of bodywork for my condition.

If I experience any pain or discomfort during this session, I agree to immediately inform Delia so that the pressure and/or methods can be adjusted to my comfort level. The therapist reserves the right to refuse services for any reason of safety.

This is a therapeutic session. Sexual advances, request for sexual favors,

and other verbal or physical conduct of a sexual nature will constitute a sexual harassment and will terminate the session. I will be liable for payment of the scheduled treatment.

Full payment is required at time of service.

Please give generous notice when canceling your session to allow for the time to be rescheduled. Cancellation within 24 hours is charged the full fee.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is a minor)