MOMENTUM THERAPIES

Client Intake Form

Name_____ Date of Birth _____

Address_____

Phone_____ Email_____ Occupation _____

Emergency Contact _____

Please indicate on the chart below if you have a history of any of the following conditions

	Past	Present		Past	Present
High Blood Pressure			**Digestive Problems**		
Blood Clots			**Menstrual Problems**		
Varicose Veins			**Broken Bones**		
Heart Disease			**Whiplash**		
Chest Pain			**Headaches**		
Depression			**Chronic Pain**		
Anxiety			**Allergies**		
Insomnia			**Skin Problems**		
Cancer			**Fibromyalgia**		
Arthritis			**Open wounds**		

List any other medical conditions, surgeries, and Medications below.

Medical Conditions_____

Surgeries _____

Medications _____

Please list below your complaints/challenges in order of their importance.

1. _____
2. _____

I understand I am responsible for payment of all therapy provided by Momentum Therapies. I agree to make payment in full at time of session. I also understand I am responsible for payment of missed or canceled appointments with less than 24 hrs notice.

Signed_____Date_____