DEMOR HOTSPOT THERAPY®

NEW CLIENT INTAKE FORM

Initial Intake Date: _____

Name: _____

Date of Birth: _____

Phone: _____

Address: _____

_____

Email: _____

Occupation: _____

Emergency Contact Information:

Name: _____ **Phone:** _____ **Relation:** _____

Primary Care Physician Information:

Name: _____ **Phone:** _____

Address: _____

Date of Last Physical: _____ **Blood Work- HDL:** _____ **LDL:** _____ **Triglycerides:** _____ **Blood Pressure:** _____

Personal and Family Medical History:

Place an **'X'** next to conditions which pertain to you and a **' * '** if the condition pertains to immediate family.

	Allergies /Food		Depression		Neck Disorder
	Allergies/Environmental		Diabetes/Type I		Osteoporosis
	Allergies/Meds		Diabetes/Type II		Neuropathy
	Anxiety		Digestive Disorder		Open Sores/Wounds
	Arthritis/Osteo		Emphysema		Past Injuries
	Arthritis/Rheumatoid		Epilepsy		Past Surgeries
	Artificial Joint		Fibromyalgia		Phlebitis
	Asthma		Frequent Colds		Recent Injury
	Atherosclerosis		Frequent Respiratory Illness		Recent Surgery
	Back Disorder		Headaches		Sprains/Strains
	Blood Clots		Headaches/Migraine		Swollen Glands
	Bruises Easily		Hernia		Tennis Elbow
	Cancer		High Blood Pressure		Thyroid Condition
	Cardiovascular Disease		High Cholesterol		TMJ
	Carpal Tunnel Syndrome		Joint Disorder		Varicose Veins
	Circulatory Disorder		Kidney Disease		Vision Disorder
	Contagious Skin Condition		Knee Pain		Other
	Current Fever		Low Blood Pressure		
	Deep Vein Thrombosis		Muscular Disease		

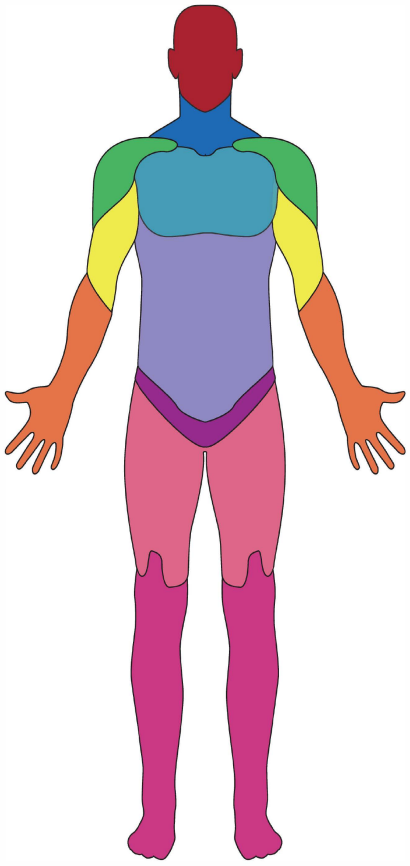
1. Are you currently taking any medications?	YES	NO
If yes, please specify:		
2. Do you have any old and/or current injuries which currently cause you pain or discomfort?	YES	NO
If yes, please specify:		
3. Do you currently feel tension, stiffness, soreness, or discomfort anywhere in your body?	YES	NO
If yes, please specify:		
4. Do you currently see a chiropractor?	YES	NO
If yes, how often?	Days/Week	
Do you feel your chiropractor has been effective in relieving your physical issues?	YES	NO
5. Have you ever had professional bodywork or massage before?	YES	NO
If yes, how often were/are you treated?	Days/Week	
Was this bodywork effective in achieving the goal you had in mind?	YES	NO
6. Do you have any difficulty lying on your front, back, or side?	YES	NO
If yes, please specify:		
7. Do you have any allergies to oils, lotions, or ointments?	YES	NO
If yes, please specify:		
8. Do you have sensitive skin?	YES	NO
9. Are you wearing…..		
Contact Lenses	YES	NO
Dentures	YES	NO
Hearing Aids	YES	NO

10. Do you currently participate in a cardiovascular training program?	YES	NO
What type? How often?	Days/Week 2	
11. Do you currently participate in a resistance training program?	YES	NO
What type? How often?	Days/Week	
12. Do you currently participate in a flexibility training program?	YES	NO
What type? How often?	Days/Week	
13. How do you generally feel about your workout?		
Before:		
During:		
After:		
14. Have you ever participated in sports?	Yes	No
What type? When?		
15. Describe your past experience with exercise:		
16. Do you perform any repetitive movement during work, physical activities or hobbies?	YES	NO
If yes, please specify:		
17. Do you sit for long hours at a workstation, computer or while driving?	YES	NO
If yes, please specify:		
18. Do you consistently feel stress in specific areas of your life?		
Work	YES	NO
Family	YES	NO
Social	YES	NO
Other	YES	NO
If yes, how do you think it has affected your health?		

Anxiety ☐ Insomnia ☐ Irritability ☐ Muscle Tension ☐ Other ☐		
Please specify:		
19. Is there any other significant information about your health that your DEMOR Hotspot Therapy practitioner should know about?	YES	NO
If yes, please specify:		
20. What goal do you want to accomplish through DEMOR HotSpot Therapy sessions?		

Please indicate any areas you are currently experiencing pain and/or discomfort:

☐ 1 LUMBER PELVIC COMPLEX
☐ 2 THORACIC SPINE
☐ 3 CERVICAL SPINE
☐ 4 SCAPULAR THORACIC WALL
☐ 5 SHOULDER
☐ 6 TRICEPS BICEPS
☐ 7 EXTENSORS FLEXSORS
☐ 8 QUADRICEPS FERMORALS
☐ 9 LOWER LEG MUSCLE GROUP
☐ 10 CRANIOSACRAL



ANTERIOR/FRONT

☐ 1 LUMBER PELVIC COMPLEX
☐ 2 THORACIC SPINE
☐ 3 CERVICAL SPINE
☐ 4 SCAPULAR THORACIC WALL
☐ 5 SHOULDER
☐ 6 TRICEPS BICEPS
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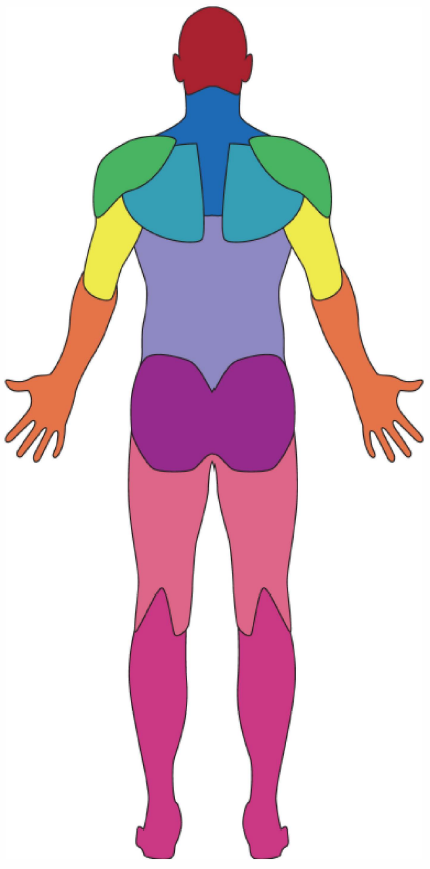

POSTERIOR/BACK

DEMOR HotSpot Therapy (DHST) Inc. Release of Liability Waiver

Male and female genitalia and women's breasts will not be exposed or massaged at any time. Draping will be used during the session and only the area being worked on will be uncovered.

_____ (Initials)

This is a therapeutic bodywork session and any sexual remarks or advances will terminate the session immediately and you will be liable for payment of the scheduled treatment.

_____ (Initials)

I verify that all information is correct and current to the best of my knowledge. I further understand that DEMOR HotSpot Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a Physician, chiropractor or other qualified medical specialist for any mental or physical ailment. I agree to keep the therapist updated on any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any information provided is for safety purposes and will be kept strictly confidential, except that such information may be used by DHST, Inc. for statistical analysis or scientific purposes.

I hereby give my consent to receive DEMOR HotSpot Therapy services and/or other bodywork and treatment (the Services) from DHST, Inc. and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such Services are my sole responsibility. I acknowledge that my receipt of the Services from DHST, Inc. may result in bodily injury to me or my death. My decision to receive Services from DHST, Inc. is voluntary, and I know of, understand and assume any and all the risks associated therewith.

In exchange for receiving Services from DHST, Inc., I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless DHST, Inc., its members, officers, employees and agents from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the Services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold DHST, Inc., its members, officers, agents and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

I, the undersigned participant, affirm that I am of the age of 17 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its content and that this release cannot be modified orally. I am aware that this is a release of liability and a contract and that I am signing it of my own free will.

Participant's Name: _____

Participant's Address: _____

_____

Signature: _____

Date: _____

PARENT / GUARDIAN WAIVER FOR MINORS

In the event that the participant is under the age of consent (17 years of age), then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent / Guardian Name: _____

Relationship to Minor: _____

Signature: _____

Date: _____