LEVERAGE
PHYSICAL THERAPY & SOUND HEALING

CLIENT INTAKE RECORD

Full name (Last, First, Middle)	
Home Address	
Home telephone number	
Mobile telephone number	
E-mail address	
Date of birth	
Gender	
Name and address of your physician / GP	
Are you currently taking any medication? (Please use additional sheets if required)	YES / NO (if yes please give details)
Please give details of recent and relevant medical treatment, operations or family history etc. (Please use additional sheets if required)	
Do you have Epilepsy?	YES / NO (if yes please give details)
Are you pregnant or trying to be pregnant?	YES / NO (if yes please give details)
Do you have any metal medical implants	YES / NO (if yes please give details)

Do you have a deep vein thrombosis in the leg or known thrombi?	YES / NO (if yes please give details)
Do you have any open wounds?	YES / NO (if yes please give details)
Do you have any acute inflammations and tumors?	YES / NO (if yes please give details)
Have you recently had any surgery?	YES / NO (if yes please give details)
Do you have carotid atherosclerosis?	YES / NO (if yes please give details)
Do you have eczema?	YES / NO (if yes please give details)
Do you have any diseased veins?	YES / NO (if yes please give details)
Do you have any inflammatory skin disorders?	YES / NO (if yes please give details)
Do you have any other inflammatory processes generally associated with fever?	YES / NO (if yes please give details)
Do you have a cardiac pacemaker, artificial heart valves, defibrillator or cardiac arrhythmias	YES / NO (if yes please give details)
Do you have a shunt?	YES / NO (if yes please give details)
Do you have a stent?	YES / NO (if yes please give details)
Do you have a deep brain stimulation device (DBS)?	YES / NO (if yes please give details)
Have you had whiplash in the last 3 days?	YES / NO (if yes please give details)
Please sign to confirm that all information given is accurate and correct at the time or writing	
Date signed	

Look at the client record and ask in relation to this about any medication, illness, stress etc. written or discussed, when it first began, if there were any significant life events that coincided	
How would you describe your diet?	
How would you describe the level and types of exercise you do?	
How would you describe your sleep patterns?	
Do you suffer from stress - and if so are there any triggers and how do you deal with them?	
How would you describe your lifestyle including any leisure activities or hobbies etc.?	
Do you smoke - if so, for how long and how many per day?	
Do you drink alcohol - if so how often and how much approx.?	
What would you say prompted you to come for this treatment?	
What would you like to get out of the treatment? If pain reduction is indicated, benchmark the current level of pain on a scale of 1 - 10 with 10 being the highest the client has ever experienced.	
Is there anything else that you think might be relevant to the treatment?	
Have you had any other complementary therapies if so which and give details?	
Have you received any kind of sound therapy in the past? If so when and give details?	