□ CC □ Thank You Note
□ Eclipse

Valeo Health & Wellness Center
Leah Shirley, MS, CMT, Neurodevelopmental Specialist

Name	**Birthdate**	**Age**	**Date**

Address	***City***	***State***	***Zip***	***Email / Newsletter***

Phone H( ) W( ) C( )	**Height**	**Weight**	**Gender**
Cell Phone Carrier			

Contact Preference □ Phone (H) □ Phone (W) □ Phone (C) □ Email □ Text

Employers Name and Address **Occupation**

Emergency Contact Information

Name **Relationship to Patient** **Phone ( )**

Please tell us who referred you to our office?	□ Single	□ Married
	□ Divorced	□ Widowed

Additional Information

Language:	**Ethnicity:**	**Race:**
English _____	Hispanic or Latino ____	White ____ Hispanic or Latino ____
Spanish _____	Not Hispanic or Latino ____	Asian ____ Black or African American ____
Other _____	Decline to Answer ____ Other ____	Decline to Answer ____ Other ____

Goals For My Care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

□ **Relief Care** – Symptomatic relief of pain or discomfort

□ **Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms

□ **Comprehensive Care** – Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible

Medical Conditions or diagnosis that should be considered prior to therapy:

Physical Limitations or concerns that should be considered prior to therapy:

Do you have any other health concerns?

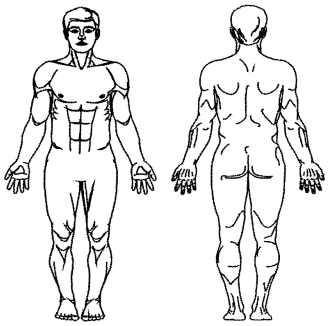
Would you be interested in an examination by one of our qualified doctors? □ **Yes** □ **No**

List all past accidents (auto or work), injuries, surgeries, X-rays, trauma, or emotional procedures

Type	**Date**	**Doctor / Hospitalization / X-Rays**

Please note body area on the diagram by marking sore area with an X

Body Area	Mild	Severe
Neck	_____	_____
Upper back	_____	_____
Lower back	_____	_____
Abdomen	_____	_____
Chest	_____	_____
Upper arms	_____	_____
Lower arms	_____	_____
Upper legs	_____	_____
Lower legs	_____	_____



Please mark with an "X" any disorder that you have experienced in the last 5 years

CARDIOVASCULAR		NERVOUS SYSTEM		SKELETAL/JOINTS		MUSCULAR SYSTEM	
Heart disease (any type)		Chronic pain / Sciatica		Osteoporosis		Muscular tension	
Blood Pressure Disorders		Shingles / herpes		Arthritis (any type)		Spasms, cramps	
Blood vessel disorders		Spinal cord injuries		Sprains / strains		Fibromyalgia	
Bleeding disorders or blood clots		Numbness / tingling		Tendonitis / Bursitis		Jaw pain / TMJ	

Details_____

Are you allergic or sensitive to any oils or fragrance? No ☐ Yes ☐ to what _____
Do you take any prescribed medication? No ☐ Yes ☐ for what _____
Have you had any surgery in the last year? No ☐ Yes ☐ for what _____
Are you pregnant? No ☐ Yes ☐ due when _____
Do you exercise regularly? No ☐ Yes ☐ what activities _____

Authorization of Care:

I understand that the therapist is not a doctor; they will not diagnose or prescribe. I understand that applied kinesiology testing and consulting are not designed for, nor are they being used as a means of any diagnosis, treating of a disease or pathology. All test results will be used as indicators of possible stress patterns and areas where the body may be out of balance. These are tools being used in accordance with their design to recognize imbalances in the body's energetic, muscle and cellular systems and then to indicate a solution to clear imbalances through various bodywork and/or nutritional supplements and/or remedies. Even though there will be references to body tissues, organs, or organ systems during the course of our sessions, these references in no way represent diagnoses or treatment of disease of any kind.

I understand that massage and bodywork it is provided for the basic purpose of relaxation, relief of muscular tension, connective tissue and rebalancing of the body. If I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the work may be adjusted to my level of comfort. I further understand that all work should not be construed as a substitute for any kind of medical exam, diagnosis, adjustments, or treatment of any kind for physical, mental or emotional condition; and nothing said in the course of any session given should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions accurately, completely, and honestly. I agree to keep the massage/bodywork practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that I am having work done at my own risk and hereby release Leah Shirley and Valeo Health & Wellness, LLC from any liability. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

The therapist is a facilitator for my own (or my child's) personal growth and understanding of that which has blocked forward progress in the desired goals of the client. I understand that I may be given home assignments to further strengthen the work I've done during a session. I take full responsibility for my personal development, whether the challenges have been physical, emotional, mental, energetic, and/or spiritual.

Client Signature / Guardian Signature (for clients under the age of 18):

Health History Information

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Leah of any changes in my health status going forward.

Signature _____ ***Date*** _____