719-339-0690
www.totalbodyworkspersonaltraining.com

ARPwave Treatment Agreement/Patient Intake form

Name _____

Address _____

City _____ **State** _____ Zip _____

Home Phone _____ **Cell Phone** _____

Occupation _____ **Work Phone** _____

Email _____ **Date of Birth** _____

Marital Status _____ **Spouse Name** _____ **Anniversary** _____

Children (Name and Age) _____ _____ _____ _____

Who Referred You* (required field):

Please check all present symptoms related to your current condition:

Are you pregnant( )
Any pacemaker or ICD( )
Any history of bloodclots( )

Primary care physician name: **Phone:**

Describe your complaint/symptoms:

Where is the location of your pain:

To help meet your needs, please indicate your specific interests:

When did your complaint/symptoms begin:

Describe your complaint/symptoms:

What was the cause of the symptoms:

How have symptoms progressed:

What treatments have you done (check all that apply):

Massage( ) Medication( ) Physical Therapy( ) Rest / Ice / Compression( ) Surgery( ) Chiropractic( ) Alternative( )

What activity bothers you the most:

What activity lessens your symptoms:

What does your pain feel like:

Rate the intensity of your pain:

Do you have any medical records that have been created :

Have you seen another doctor because of your current condition:

If so, the name of the Physician:

If so, what was the result:

Do you have any allergies, if so list them:

Have you had any diagnostic tests performed by any Doctors (check all that apply):

MRI( ) X-Rays( ) Lab Work( ) Functional Testing( ) Psychological Testing( ) Electro diagnostics( ) Other( )

If so, what were the results of the test :

Are there any additional comments about your condition that you feel would be important for us to know:

Total Body Works/ARP Wave is committed to excellence. Our goal is your complete satisfaction. Below are the terms and conditions of our program. If you have any questions or concerns, please address them with your Therapist

- **~ No refunds will be issued for any reason, including but not limited to; Relocation, illness, and/ or un-used sessions.**
- **~ To provide timely scheduling of all our clients/patients- If you need to cancel or reschedule a session- it needs to be done within 24 hours of your appointed time or forfeit that session.**
- **~ Clients/Patients arriving late will receive the remaining scheduled session time unless prior arrangements have been made with your therapist.**
- **~ Clients/Patients will complete a Health History Form prior to their 1st treatment.**

Truthful Representation:

Upon selecting the following box stating "ALL INFORMATION IS TRUE" I hereby state that all the information I have provided is true, correct and complete. If more information about my condition becomes known, I will tell the doctor when possible so that it can be added to my record:

ALL INFORMATION IS TRUE( )

Release of Liability

Release of Liability:

In conjunction with my treatment with the ARP at ARP Wave Clinic and as part of the consideration for my treatment, I, my heirs, executors, spouse, successors, assigns, offspring, agents, and representatives expressly release, hold harmless, and indemnify the ARP Wave Clinic its owners, agents, employees, representatives, assignees, licensees, and invitees, from all liability for any treatments given.

Signature _____ **Date** _____