initial intake

therapist: _____

name: _____ date: _____ time: _____ duration & fee: _____

primary concern

treatment consent ☐
assessment consent ☐

Subjective information:

Assessment & findings

limitations of ADL's: _____

CI's/RISKS: _____

client goal/treatment goal: _____

areas treated:

- ☐ full body
- ☐ face
- ☐ head
- ☐ neck
- ☐ shoulders
- ☐ chest/pecs
- ☐ upper back
- ☐ lower back
- ☐ glutes
- ☐ hips
- ☐ arms
- ☐ wrists/hands
- ☐ legs
- ☐ feet
- ☐ abdomen
- ☐ breast
- ☐ intra-oral
- ☐ other: _____

- ☐ compression
- ☐ GST
- ☐ fascial
- ☐ GTO
- ☐ TRP
- ☐ hydrotherapy
- ☐ stretch
- ☐ frictions

- ☐ jt mobs: _____
- ☐ dynamic release
- ☐ tapotement
- ☐ other: _____

clinical findings/objective info _____

client reaction/feedback _____

self-care: _____