Aches Away tm
massage specialists

CLIENT INFORMATION – SPINAL FLOW INTAKE & RELEASE FORM

Personal Information

Name: _____ Date: _____ Date of Birth: _____
Address: _____ City: _____ State ____ Zip _____
Phone: _____ Occupation: _____ Email: _____
Emergency Contact Name and Phone: _____
How did you hear about Aches Away / Spinal Flow? *(Online search, social media, current customer)*
_____

Health Information

Please identify any conditions you have had or are currently experiencing (Check any that apply) and provide any additional comments as needed in the space provided.

___Nervous system issues	___Anxiety	_____
___Neurological disorders	___Depression	_____
___Feeling stuck in fight or flight	___Feeling ungrounded	_____
___Sciatica	___Hip Issues	_____
___Groin problems	___Knee Pain	_____
___Feeling stuck in the past / can't move forward / hard to make decisions		_____
___Feeling unsupported		_____
___Low back pain		_____
___Spinal disk problems	___Digestive issues	_____
___Reproductive issues	___Constipation	_____
___Feeling disempowered, no drive in life		_____
___Breathing issues (asthma, etc.)	___Chest pain, heartburn	_____
___Indigestion, trouble with fatty foods	___Gas, burping	_____
___High or low blood pressure	___Kidney issues	_____
___Bladder issues	___Rarely prioritizing yourself	_____
___Feeling like the weight of the world is on your shoulders		_____
___Trying to hide or protect your heart		_____
___Neck, shoulder or arm pain	___Food Sensitivities	_____
___Sore throat, thyroid issues	___Tiredness after eating	_____
___Swollen glands		_____
___Feel like you need to swallow your words & thoughts, can't speak your truth		_____
___Headaches, migraines	___TMJ, sinus problems	_____
___Colds, flu, earaches, tinnitus	___Sleep disorders, snoring	_____
___Busy mind / racing thoughts / stuck in the future		_____
___Learning disorders		_____
___Low energy	___Spaciness, dizziness	_____
___Feeling depleted and disconnected	___Memory issues, brain fog	_____

Your Birth Story

Was the delivery long and/or difficult?	Yes / No / Don't know	_____
Were forceps used?	Yes / No / Don't know	_____
Was the birth Cesarean?	Yes / No / Don't know	_____
Breech / Cephalic?	Yes / No / Don't know	_____
Mother given medication during delivery?	Yes / No / Don't know	_____
Was labor induced?	Yes / No / Don't know	_____

Growth and Development (Age 0-5)

Did you roll out of bed as a child?	Yes / No / Don't know	_____
Childhood sicknesses?	Yes / No / Don't know	_____
Chair pulled out when sat down?	Yes / No / Don't know	_____
Did you fall down stairs / fall from height?	Yes / No / Don't know	_____
Any other trauma? If so, what & when?	Yes / No / Don't know	_____

Growth and Development (Age 5–Present)

Were you taught proper body movement and care?	Yes / No / Don't know	
Did / Do you smoke?	Yes / No	_____
Did / Do you drink alcohol?	Yes / No	_____
Did / Do you take any drugs (OTC, controlled, illicit)?	Yes / No	_____
Healthy diet?	Yes / No	_____
Have you been in any accidents? (if yes, please explain)	Yes / No	_____
Have you had any surgery and/or organs replaced / removed?	Yes / No	_____ _____
Teeth problems?	Yes / No	_____
Eye problems?	Yes / No	_____
Hearing problems?	Yes / No	_____
Exercise regularly?	Yes / No	_____
Poor sleep / nightmares?	Yes / No	_____
Occupational stress?	Yes / No	_____
Physical and / or mental stress?	Yes / No	_____
Hobby / sports injuries?	Yes / No	_____
Any other traumas or injuries? (please explain)	Yes / No	_____
Sleeping Posture (Check all that apply)	___Side	___Stomach ___Back

Is there something concerning that brings you here today? _____

_____

_____

When did the pain or problem start? _____

How would you describe the pain? ___Sharp ___Dull ___Constant ___Intermittent

Is the condition getting worse? Yes / No

Are there activities that aggravate the pain? _____

Are there activities that lessen the pain? _____

Is this condition interfering with: ___Work ___Sleep ___Routine ___Other (please explain)

_____

Any doctors seen for this condition? _____

Any alternative / complementary / home remedies? _____

Family History

Heart Disease	__Mother's Side	__Father's Side	_____
Arthritis	__Mother's Side	__Father's Side	_____
Cancer	__Mother's Side	__Father's Side	_____
Diabetes	__Mother's Side	__Father's Side	_____
Others	__Mother's Side	__Father's Side	_____

*****************Please take a moment to carefully read the following information and sign where indicated******************

In Spinal Flow sessions, the practitioner focuses on increasing the spinal flow and decreasing blockages in the spine. As a result, you may experience relief or lessening of symptoms that were associated with the blockages and impaired flow. However, your Spinal Flow practitioner does not diagnose, prescribe, or treat any physical or mental illness, and nothing said in the session(s) should be construed as such.
Your initial Spinal Flow appointment includes a posture and gateway assessment, discussion of findings, creating a service plan, and first Spinal Flow session. With your consent, before/after progress photos can be taken using your phone to document progress. Multiple and frequent Spinal Flow sessions are recommended when you start your Spinal Flow journey (2-4 sessions a week, with a reassessment after the 12th session).

Please read and sign the acknowledgement.

I understand that it is my responsibility to consult my physician regarding questions included on this Spinal Flow Intake & Release Form, and any other considerations pertaining to my current medical status that may affect delivery of this service. I understand that the Spinal Flow therapist does not diagnose illness, and, as such, the Spinal Flow therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation. I am aware that Spinal Flow is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any ailment that I may have. I understand and I agree that I am receiving Spinal Flow entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid Spinal Flow therapy, I hereby hold harmless and indemnify the Spinal Flow therapist, their principals, and agents from all claims and liability whatsoever.

Aches Away may request credit card information to hold appointments in situations where clients have missed appointments and do not call to cancel within 24 hours.

Signed: _____ Date: _____