

# Consumer Interview and Consent Form

SW Therapy & Rehab, LLC  
EIN: 27-3506899, NPI 1134299555

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_  
Office/ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_  
Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## PERSONAL HISTORY

Date of Birth: \_\_\_\_\_ Current age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Occupation: \_\_\_\_\_ FT: \_\_\_\_\_ PT: \_\_\_\_\_ Hrs. per Wk: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Number and Ages of: Siblings: \_\_\_\_\_

Children: \_\_\_\_\_

Grandchildren: \_\_\_\_\_

Family members now deceased and cause of death: \_\_\_\_\_

Parent's marital status during childhood: \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

List any significant events, accidents, traumas and the date they occurred:

List any medications you are currently taking: \_\_\_\_\_

Do you Smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often/ for how long: \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what types and how often: \_\_\_\_\_

Do you use stimulants (Coffee, tea drugs, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what types and how much: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ (MD, DO, DC, OMD) Phone: \_\_\_\_\_

Who referred you to SW Therapy & Rehab, LLC? \_\_\_\_\_

Relationship: \_\_\_\_\_

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## MEDICAL HISTORY

Date of last Physical Exam: \_\_\_\_\_ Blood Work: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Have you ever had surgery: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Year: \_\_\_\_\_ Please describe: \_\_\_\_\_

Please indicate below by marking as follows: 1 = present condition 2 = previous condition

- |                                     |                           |                              |
|-------------------------------------|---------------------------|------------------------------|
| _____ Headaches                     | _____ Disc Problems       | _____ Ulcers                 |
| _____ Dizziness                     | _____ Hip Pain            | _____ Diarrhea               |
| _____ Neck Pain                     | _____ Leg Pain            | _____ Constipation           |
| _____ Lightheadedness upon standing | _____ Knee Pain           | _____ Prostate Problems      |
| _____ Neck Tightness                | _____ Ankle               | _____ Impotence              |
| _____ Shoulder Tightness            | _____ Foot Pain           | _____ Implanted Virus        |
| _____ Numbness & Tingling           | _____ Arthritis           | _____ Urinary Tract Problems |
| _____ Elbow Pain                    | _____ Tendonitis/Bursitis | _____ High Cholesterol       |
| _____ Upper Back Pain               | _____ Fatigue             | _____ High Blood Pressure    |
| _____ Mid- Back Pain                | _____ Frequent Colds      | _____ Heart Condition        |
| _____ Low-Back Pain                 | _____ Asthma/Bronchitis   | _____ Diabetes Type I        |
| _____ Back Stiffness                | _____ Allergies           | _____ Diabetes Type II       |
| _____ Blood Clots                   | _____ High Stress         | _____ Varicose Veins         |

Other \_\_\_\_\_

Please list below any family members who have had the following:

Heart Disease: \_\_\_\_\_

Stroke: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Liver Disease: \_\_\_\_\_

Cancer: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

Other: \_\_\_\_\_

Do you have skin rashes, irritations, or open sores? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

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Do you exercise regularly or participate in any sports? Yes \_\_\_\_ No \_\_\_\_

If yes, how often/ what kind: \_\_\_\_\_

Have you had any problems keeping weight off/on in the past or present? Yes \_\_\_\_ No \_\_\_\_

If yes, what do you feel is the most likely cause? Improper diet: \_\_\_\_ Lack of or inconsistent exercise: \_\_\_\_

Mental/emotional stress: \_\_\_\_ Other: \_\_\_\_\_

Any particular food cravings \_\_\_\_\_

Which, if any, of the following medications are you presently taking:

- |                                |                                     |
|--------------------------------|-------------------------------------|
| ____ Antacids                  | ____ High Blood Pressure Medication |
| ____ Antidepressants           | ____ Hormones                       |
| ____ Aspirin/Tylenol/Ibuprofen | ____ Oral Contraceptives            |
| ____ Anti-inflammatories       | ____ Pain Killers                   |
| ____ Antibiotics/Antifungal    | ____ Relaxants/Sleeping Pills       |
| ____ Anti-diabetic/Insulin     | ____ Thyroid Medication             |
| ____ Chemotherapy              | ____ Ulcer Medication               |
| ____ Heart Medications         | ____ Other _____                    |

Please list any vitamin/mineral supplementation you are presently taking: \_\_\_\_\_

Have you ever had a professional therapeutic massage? Yes \_\_\_\_ No \_\_\_\_ If yes, how long ago? \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_ No \_\_\_\_

Any problems with: Sleep \_\_\_\_ Dreaming \_\_\_\_ Appetite \_\_\_\_ Digestion \_\_\_\_

If yes, please elaborate: \_\_\_\_\_

## REASONS FOR SESSION

What is the primary reason for your appointment today?

Briefly describe any symptoms and how long you have had them.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your condition been professionally diagnosed and, if so, by whom?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Based upon your own experience with the condition, share any additional information or personal insights which you feel might be helpful.

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What results would you like to see from this initial session? \_\_\_\_\_

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## UNDERSTANDING AND CONSENT

**I understand that muscle checking accesses my innate bodily intelligence – that part of me which governs my heart rate, breathing and other bodily functions that occur without my conscious awareness. Any information revealed by my innate bodily intelligence is for educational purposes and is to be weighed by me and discussed with my medical doctor(s) as needed and is not to be misconstrued as a medical diagnosis.**

**I understand that the practitioner is not a doctor, does not diagnose illness, disease or any other physical or mental disorder. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor does the practitioner perform any spinal manipulations. It has been made very clear to me that this energy/body work is not a substitute for medical examination and /or diagnosis and it is recommended that I see a physician for any physical ailment that I might have.**

**Because it is important for this practitioner to be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical health.**

**I consciously consent to this and subsequent sessions should I choose to continue treatment.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_**