A Healing Movement Studio
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New Client Profile

First Name _____ **Last Name**_____ **Date** _____

Health Assessment

Cardiac Problems?_____ Osteoporosis?_____ Pregnant? _____
Lung Problems? _____ Osteoarthritis? _____ Due Date? _____
Asthma? _____ Arthritis? _____
Epilepsy? _____ Unstable Weight? _____ Medications? _____
Fibromyalgia? _____ Sleeping Troubles? _____ What for? _____
Other (explain) _____ _____

Why are you here today? _____ Chronic Injuries? What? Since When? _____
_____ _____
_____ _____
_____ _____

Surgeries? What? When? _____ Functional limitations or disabilities? _____
_____ _____
_____ _____
_____ _____

Accidents or acute injuries? What? When?___ Physical activities and frequency?_____
_____ _____
_____ _____
_____ _____

Physician Name _____ Physician Telephone _____

My Goals: What results would you like to gain from our work together? _____
_____
_____

How often would you like to practice at Align Davis? _____
Do you have a home program? _____

24 Hour Cancellation Agreement

Please Initial_____ I understand that I am responsible for full payment of the service charge if I do not give a *minimum* of 24 hours cancellation notice for any scheduled session.