Information Sheet

Name_____ Date _____

Address _____

City _____ State _____ Zip _____

Work Phone _____ FAX _____

Home Phone _____ Cell Phone _____

E-mail _____

Age _____ Date of Birth _____ Sex _____ Weight _____Height _____

Occupation _____ Referred by _____

Medical Doctor or Chiropractor _____

Location of Office _____ Phone number _____

Hobbies/Sports _____

_____

Best time to reach you _____

Are you interested in learning more about nutritional supplements? ☐ Yes ☐ No

Informed Consent

_____By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of a progressive physical exercise and/or nutritional program. By signing this document, I acknowledge being informed of the risk and assume all risk for my health and well-being and hold harmless of any responsibility of Health Through Motion Inc., Frank Titus, the Therapist, the Health Through Motion center or any of its other facilities used with Titus Motion Therapy. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

Waiver

_____Buyer acknowledges and understands that prior to the beginning any exercise and/or nutritional program that he/she consult with and/or receive approval of a physician. Buyer understands that any exercise program involves risks and voluntarily assumes the same by executing this Agreement. Buyer acknowledges and understands that he/she is using the facilities and services of Health Through Motion at his/her own risk. Health Through Motion and their owners, officers. Employees, agents, contractors and affiliates shall not be liable, and Buyers hereby expressly waives any claim of liability for personal/bodily injury or damages, which occur to Buyer or any guest(s) for any loss of or injury to person or property.

CONFIDENTIAL CASE HISTORY

Females, are you pregnant? ☐ Yes ☐ No
Please check your major complaints (please circle appropriate side):

☐ Headaches
☐ Pain Down Rt/Lt Leg
☐ Neck Pain
☐ High Cholesterol
☐ Ringing in Ears
☐ Overweight
☐ Lower Back Pain
☐ Shoulder Pain
☐ Pins & Needles in Rt/Lt Arm
☐ Fatigue
☐ Loss of Balance
☐ High Blood Pressure
☐ Upper Back Pain
☐ Depression
☐ Numbness in Rt/Lt Hand/Foot
☐ Loss of Memory
☐ Loss of Smell

Symptoms other than those listed above: _____

What is the cause of this condition: _____

When did it start? _____

What activities make it worse? _____

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily Activities ☐ Other (please explain) _____
_____

Please list previous accidents, injuries and/or major illnesses: _____
_____
Have you ever had surgery? ☐ Yes ☐ No If yes please describe and give dates _____
_____

Are you taking any prescription or non-prescription drugs or medication? ☐ Yes ☐ No
If yes, please give names and indicate for what condition: _____
Have you seen any other doctor for this condition? ☐ Yes ☐ No
If yes, please give names, diagnosis and result: _____
_____
What else have you done to treat this condition? _____
_____

I do hereby certify that all of my statements on this application for therapy are true, accurate, and complete.

Signature _____ Date _____