Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

Limber Intake

Name: ______________________________ Date of Birth: ___/___/___

Address: ______________________________

City: ______________________ State: ________ Zip: ______________

Phone (H): ______________ (C) ______________ Email: ______________

Occupation: ______________________________

How did you hear about Limber? ______________________________

When was the last time you stretched? ______________________________

What are your Limber goals?

☐ Flexibility ☐ Mobility ☐ Pain Management ☐ Rehab for Injury

Have you ever received assisted stretching?

☐ Yes ☐ No

Would you like to hear about our Limber Treatment Plan?

☐ Yes ☐ No

What limits your ability to stretch?

☐ Time ☐ Do Not Know Enough Stretches ☐ Stretch Isn't Deep Enough

☐ Do Not Know How To Stretch a Specific Area

Do you have a main focus or target area for today's session? ______________________________

How would you prefer to be contacted?

☐ Text ☐ Email ☐ Phone

Please list any daily activities that may cause you pain, discomfort, or stress (including exercising, daily work activities, ect.): ______________________________

____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

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Health History

Please be thorough in answering the following questions regarding your health history. Simple Health follows strict HIPAA guidelines and your information will be kept confidential. We require this information to ensure the safety of your therapist and to maximize the benefit of your treatment.

Do you currently have or have you had any of these conditions in the past? Please check any boxes that may apply to you and provide an explanation.

- ☐ Sprains: ______________________________
- ☐ Torn Ligaments ______________________________
- ☐ Allergies (sp. Coconut) ______________________________
- ☐ Blood Conditions (clots, anemia, high/low pressure) ______________________________
- ☐ Chronic Pain ______________________________
- ☐ Diabetes ______________________________
- ☐ Fibromyalgia ______________________________
- ☐ Headaches ______________________________
- ☐ Heart Conditions ______________________________
- ☐ Infections (including STDs) ______________________________
- ☐ Injuries ______________________________
- ☐ Immune System Deficiencies ______________________________
- ☐ Pregnancy (see front desk for addiontal forms) ______________________________
- ☐ Skin Conditions ______________________________
- ☐ Surgeries ______________________________
- ☐ Spinal Problems ______________________________
- ☐ Other ______________________________

Signature ______________________________ Date: ______________

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LIMBER WAIVER AND RELEASE OF LIABILITY

In agreeing to receive care, including but not limited to the Limber Assisted Stretching Program provided by Simple Health Acupuncture & Chiropractic (hereafter known as Simple Health), and to use the facilities provided by Simple Health located at 3939 Atlantic Ave, Ste 203, Long Beach, CA 90807, I agree as follows:

I certify that I am voluntarily participating. I fully understand and acknowledge that the activities in which I will engage as part of the treatment provided by Simple Health, and any equipment I may use as part of that treatment have inherent risks, dangers, and hazards, and such exists in my participation in these activities. I understand that there are possible risks during the process of assisted stretching and other similar types of therapies, and that these risks may be including but are not limited to physical and/or psychological injury, pain, suffering, disease, and temporary or permanent disability, which may occur from my participation. These risks and dangers may be caused by the negligence of the representatives or employees of Simple Health, the negligence of the participants, the negligence of others, inactions, accidents, breaches of contract, or other causes.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Simple Health and their representatives, employees, and assigns from any and all claims, actions, or losses for bodily injury, property damage, wrongful death, loss of services, or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representative or employees of Simple Health.

If I need medical treatment, I agree that Simple Health is authorized to obtain medical treatment for me. I alone will be financially responsible for any costs of such treatment incurred. I agree that I will not hold Simple Health responsible for any claims resulting from any medical treatment incurred as a result of services rendered at Simple Health.

I have read the above waiver and release, and I am signing it freely. I understand the legal consequences of signing this document, including (a) releasing Simple Health from all liability, (b) waiver of my right to sue Simple Health, and (c) assumption of all risks of participating in Limber.
I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms.

Participant Name:______________________________ Date:_______________

Signature: ____

If Participant is under 18 years of age:
I am the parent or legal guardian of the Participant. I have read this document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) release of Simple Health from all liability on my and the Participant's behalf, (b) waiver of my and the participants' right to sue, and (c) assumption of all risks of the Participant's participation in Limber. I allow Participant to participate in Limber. I understand that I am responsible for the obligations and acts of Participant as described in this document. I agree to be bound by the terms of this document.

Participant Name: ____________________ Parent/Guardian Name: ____________________

Signature of Participant's Parent/Guardian:____________________ Date:____________

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SIMPLE HEALTH LATE CANCELLATION AND MISSED APPOINTMENT POLICY

At Simple Health, we understand that unanticipated events happen occasionally in life. While truly sympathetic, the clinic cannot absorb the financial responsibility of last minute cancellations. In our desire to be effective and fair to all clients, the following policies are in effect.

All appointments require a 24-hour notice for cancellation. This allows the opportunity for someone else to schedule an appointment. Any late cancellations or no-shows within less than 24 hours of appointment time are subject to a fee of **$25**.

Massage Appointments:

Since all massage services are by appointment only, a major credit card on file is required to hold your appointment. Your credit card will not be charged until services are rendered, unless you fail to cancel within 24-hours and/or no-show to your appointment. If you are unable to give us 24-hours notice, your credit card on file will be charged a fee of $25. **You have the option to pre-pay for your massage if you do not want to have a credit card on file.**

Pre-Paid Package Appointments:

If you have a Pre-Paid package for any service and you are unable to give us 24-hours advance notice to cancel your appointment, you will be billed a fee of $25. If you do not have a credit card on file, you have 3 business days to pay the cancellation fee, otherwise a session will be deducted from your package equal to the missed appointment time.

We have tried to make this information clear and understandable. Should you have any additional questions, please feel free to discuss this with our reception.

☐ I have read the following information above and have been informed of the policies and procedures regarding cancellations.

Patient Signature: ____ Date: ____________________

Staff Signature: ____ Date: ____________________

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SIMPLE HEALTH CREDIT CARD ON FILE AUTHORIZATION

Information to be completed by the card holder:

Card holder Name: ____

Card Number: ____

Card Type: ____Expiration Date: _________

Security Code: ___________________ (3 digit code on back or 4 digit code in front for AMEX)

Billing Zip Code: __________________

Email: ____

Per the Cancellation/ No-show Policy which I have read and signed

I, ____ authorize Simple Health Chiropractic to charge the above credit card in the amount of $25 for any late cancellation or no-show appointments. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Card holder Signature: ____ Date: _______________