NEUROBALANCE
CENTER

1529 S. Grove Avenue, Barrington, IL 60010 | Phone 847.800.6162 | Fax 847.660.6389

Name _____ Date of Birth: ___ / ___ /_____

Address _____

City _____ Zip Code _____

Phone _____ Email _____

Emergency Contact Name and Relationship _____

Emergency Contact Phone Number _____

Diagnosis _____

What areas are you most interested in improving?

Mobility Challenges	Balance & Coordination	Muscle Strength

Please circle all programs/services that interest you:

Group Fitness Classes (fitMS, fitPD, fitYoga, fitBarre)	Chiropractic Disease Management Consultation	Clinical Therapeutic Massage
Adaptive Boxing Classes	Speech Therapy	Physical Therapy
Pilates Reformer Training	Adaptive Golf	Personal Training
Infusion Services	Occupational Therapy	Functional Neurology

Hobbies _____

Favorite types of music _____

[ ] I authorize NBC providers to share my medical, wellness and mobility information between NBC providers for the purpose of ensuring safety measures related to my health, as well as, to provide continuity of care. I understand that this information will not be shared outside of NBC providers.

[ ] I give NeuroBalance Center and its practitioners consent to share information with and request information from _____ (please state their name and relationship to you) pertaining to my health & wellness in order to compliment my care plan.

Signature _____ Date _____

STAFF USE ONLY:
MindBody ID:

Liability and Media Waivers

I hold fitMS NeuroBalance Center, NFP harmless of claims, demands or causes of action (including the cost of defense thereof) as a result of any personal injury or personal property loss or damage suffered by myself arising out of or connected with the use of fitMS NeuroBalance Center facility located at 1529 S. Grove Avenue, Barrington IL 60010, including equipment and/or services regardless if such injury, loss or damage was foreseeable or the result of active or passive negligence of the office space, building, workout rooms, its Partners or Employees.

___ I agree ___ I do NOT agree

Media Release

I allow fitMS NeuroBalance Center, NFP to publish or broadcast my image, likeness or name for promotional purposes associated with fitMS NeuroBalance Center.

___ I agree ___ I do NOT agree

_____ _____

Printed Name Date

_____

Signature

Witnessed by:

_____ _____

Printed Name Signature

_____

Date