

# CLIENT INTAKE FORM

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant Health Conditions: \_\_\_\_\_

Medications Being Taken: \_\_\_\_\_

Please indicate any of the following conditions that you currently have:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> headaches                  | <input type="checkbox"/> allergies        | <input type="checkbox"/> arthritis, tendonitis     |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> TMJ              | <input type="checkbox"/> abnormal skin condition   |
| <input type="checkbox"/> heart/circulation problems | <input type="checkbox"/> joint surgery    | <input type="checkbox"/> high / low blood pressure |
| <input type="checkbox"/> major accident             | <input type="checkbox"/> varicose veins   | <input type="checkbox"/> blood clots               |
| <input type="checkbox"/> neck / back injuries       | <input type="checkbox"/> diabetes         | <input type="checkbox"/> fibromyalgia              |
| <input type="checkbox"/> numbness                   | <input type="checkbox"/> sprains, strains | <input type="checkbox"/> recent injuries           |

Explain Any Conditions You Have Marked Above:

---

---

---

---

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