# New Client Intake Form

Name: ______________________________ Date: ____________________

Address: ____________________________________________________

DOB: ______________ Cell Phone: ______________ E-mail: ____________________

Referring Practitioner: ______________________________ Phone #: ____________________

What brings you here today?

_____________________________________________________________

Please describe any symptoms you're having. *(Intensity -- 0-10, with 0 being healthy and 10 being the worst)*

| **Symptom** | **Intensity** (1-10) | **How or when started?** | **Frequency** | **What makes it better?** | **What makes it worse?** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

List any major life changes, surgeries, serious injuries, or illnesses in the last five years?

- ______________________________ Date: ____________
- ______________________________ Date: ____________
- ______________________________ Date: ____________
- ______________________________ Date: ____________
- ______________________________ Date: ____________

Medical History: Please any significant illnesses in your family?

_____________________________________________________________

_____________________________________________________________

Use of non-prescription medication (e.g., aspirin, Tylenol, decongestants, sleep medications, nasal sprays, inhalers, diet pills, vitamins, other supplements).

_____________________________________________________________

_____________________________________________________________

Name:____________________

Please check all that apply or have applied to you at any point in your life.

| | | Comments |
|---|---|---|
| Allergies | | |
| Anemia | | |
| Anxiety | | |
| Arthritis | | |
| Asthma | | |
| Attention Deficit Disorder | | |
| Cancer | | |
| Chronic Headache | | |
| Dental Problems (Bruxism, etc) | | |
| Dizziness | | |
| Epilepsy | | |
| Fainting | | |
| Heart Disease | | |
| High Blood Pressure | | |
| Insomnia | | |
| Migraines | | |
| Muscle Tension | | |
| Pace Maker | | |
| Panic Attacks | | |
| Respiratory Illness other than Asthma | | |
| Sleep Apnea | | |
| Seizures | | |
| Substance Abuse | | |
| Thyroid Problems | | |
| Ulcers | | |
| Other | | |

Use of stimulants (please circle and describe frequency).

Alcohol ________________________________________ Cigarettes ________________________________________

Coffee/Tea ________________________________________ Other Substances ________________________________

Quality of Sleep: What time do you go to sleep? _______________ What time do you wake up? _______________

On average, do you sleep continuously through the night without waking? □ Yes □ No

How would you describe your energy level on a typical day? (ex. motivated, tired, hyper, etc)

Morning _________________ Day ____________________ Evening _____________________

Nutritional habits (detailed description of one day's typical meals).

Breakfast ____________________________________________________________________________________

Lunch _______________________________________________________________________________________

Dinner ______________________________________________________________________________________

How often do you eat out?_____________________________________________________________________

What is your level of physical activity: High Medium Low

List what you do for exercise

______________________________________________

What do you do to relax when you are feeling tension or stress?

______________________________________________

List any medical practitioners you are currently seeing (physician, psychologist, massage, acupuncture, etc)

______________________________________________

______________________________________________

List any medications you are currently taking (include dosage levels and reasons)

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Is there any additional medical information in your past or present that you would like to comment on?

______________________________________________

______________________________________________

______________________________________________

Please provide a brief statement of what you hope to accomplish during our time together:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Thank You for Completing this Form**
**All Information is Confidential**