CLIENT INTAKE FORM 2025 (English)

Name, Middle, Last Name _____

Email: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Driver License #/ State: _____

Referred By: _____ Doctor (s): _____

Name and Address of Primary Physician: _____

_____

The information collected will help your practitioner assess your health and design a protocol that will best fit your needs. All information is confidential. Every year we update on all client health history and any new health concerns.

NO ☐	YES ☐	Any injury or accident? What injury and list dates:
NO ☐	YES ☐	Please list allergies?
NO ☐	YES ☐	Asthma? List medications
NO ☐	YES ☐	Diabetes? List medications
NO ☐	YES ☐	Headaches? How often? List medications
NO ☐	YES ☐	High Blood Pressure? List medications
NO ☐	YES ☐	Arthritis? Describe and list medications
NO ☐	YES ☐	Candida? How long?
NO ☐	YES ☐	Constipation? Frequency? Describe
NO ☐	YES ☐	Diarrhea? Describe
NO ☐	YES ☐	Insomnia? How long?
NO ☐	YES ☐	Gastritis?
NO ☐	YES ☐	Surgery? Description and date
NO ☐	YES ☐	Pregnant? How long?
NO ☐	YES ☐	Eat pork? How often?

CLIENT INTAKE FORM 2025 (English)

NO ☐	YES ☐	Drink Coffee? How much per day?
NO ☐	YES ☐	Drink sodas? ☐Regular or ☐diet? How many per day?
NO ☒	YES ☐	Have you had a hydro colon therapy before? List last date

Other comments: _____

_____

Describe the reason for your visit today. How long have you been dealing with this issue?

_____

_____

_____

List all medications with dosage and reason for taking. (If you need a larger piece of paper, please request one) _____

_____

_____

List vitamins and supplements that you are presently taking with the dosage and reason: _____

_____

_____

_____

I understand that the information I provided is true and correct. I understand that Distinct Touch is to assist me in evaluating my health. I am not being diagnosed. I understand that this will not replace physician care. I am not to be diagnosed.

This information will be kept private and confidential. I will have to sign a release form prior to sharing my information with other family members, professionals, doctors, insurance companies, or organizations.

I agree to pay all invoices in full at the time-of-service _____ (initial please). Any checks made and returned due to NSF will be assessed a $35.00 NSF per transaction _____ (please initial). Any uncollected balances will be turned over for collections and any legal fees assessed will be my responsibility _____ (please initial).

SIGNATURE: _____ DATE: _____