Client Intake Form

Client Information

Client Name (first, last) Date of Birth	
Address	
Phone Number	
Email Address	
Emergency Contact (name, phone, relationship)	
Drug Allergies	

Medical History (circle those that apply)

High Blood Pressure	Circulatory Problems	Radiation Treatment
Low Blood Pressure	Asthma / Shortness of Breath Emphysema / COPD	Cancer (active or remission)
Headaches	Sinus Problems	Swelling of legs/ankles
Heart Disease	Persistent Cough (with or without blood)	Irritable Bowel Syndrome / Crohns
Heart Murmur	Arthritis / Rheumatism	Anxiety
Heart Attack	Diabetes	Depression
Stroke / TIA	Thyroid Disease	Kidney Disease / Dialysis
Heart Defect	Lupus	G6PD
Artificial Heart Valves	Multiple Sclerosis	Osteoporosis
High Cholesterol	Liver Disease	Neuropathic Pain

Other Medical Conditions: _____

_____

To be completed annually. 2/2023

Do any of these apply at this time?

Are you under a physician's care?	YES	NO	for:
Are you currently being treated for cancer of any kind?	YES	NO	what type:
Are you currently breastfeeding / pumping?	YES	NO	-
Taking birth control pills?	YES	NO	
Do you smoke, vape, or use tobacco?	YES	NO	which:
Do you consume alcohol?	YES	NO	last use:
Have you ever had an adverse / bad reaction to a medical treatment?	YES	NO	Describe:

Please list All current medications / herbs / vitamins / pain meds / illicit drugs

_____ _____

Client Signature Date

_____ _____

Reviewing Provider Date

To be completed annually. 2/2023