

Client Intake Form

Full Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Email:** _____

Occupation: _____

Emergency Contact: _____ **Phone #:** _____

Relationship: _____

Physician: _____ **Phone #:** _____

Medical History

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:

(Please also note any additional conditions not listed that I should know about)

Client Signature: _____ **Date:** _____