# CLIENT INTAKE FORM

Date:_____

Confidential - for Practitioner's use only

Name _____

Address _____

_____

Telephone: (hm) _____ (wk) _____ Email: _____

Date of Birth _____ Relationship Status: _____ Children _____

Physician – name & telephone _____

Therapist – name & telephone _____

Emergency Contact & telephone _____

Reason for Visit _____

_____

_____

Current and/or previous treatments for above complaint _____

_____

_____

_____

Date of onset: _____ Sudden ____ Slow _____ Referred by _____

Accidents/Injuries _____

Surgeries (date and type) _____

_____

Current Medications _____

_____

Complementary Medications (vitamins/homeopathic) _____

_____

Eating habits/Diet _____

Exercise Routine _____

Amount of Fluid intake daily (approx): Water _____ Caffeine _____ Sodas _____

Do you drink Alcohol? Y / N : Amount per day ___ Do you Smoke? __ Quantity _____

Vision _____ Wear Glasses/Contacts _____ Hearing ____ Taste_____ Smell _____

**Do you have or have you had any of the following: Please mark areas of diseases or symptoms as: 'C' for current, 'P' for past, and 'CH' for chronic. Please note any other ailments not listed.**

## Emotional/Psych.

___ Depression
___ Eating Disorder
___ Mood Swings
___Substance abuse
Type: _____

## Auto-Immune

___ AIDS/HIV
___ Allergies
___ Cancer
Type: _____
___ Fatigue
___ Fibromyalgia
___ Fungal Infection
Type: _____
___ Herpes
Type:_____
___ Lymes
___ Mononucleosis
___ Epstein Barr

## Endocrine

___ Adrenal insuff.
___ Pituitary dysf
___Hyper thyroid

## Neurological

___ Epilepsy
___ Dizziness
___ Insomnia
___ Migraines
(Stress/Hormonal)

## Musculo-Skeletal

___ Arthritis
___ Back Pain
___ Carpal Tunnel
___ Gout
___ Skin Disorder
Type: _____

## E N T

___ Earaches (chronic)
___ Headaches
___ Jaw Pain

## Cardiovascular

___ Angina
___ Heart Attack
___ Heart Failure
___ Hypertension
Stroke _____

## Urinary

___ Bladder infections
___ Kidney Stones

## Respiratory

___ Bronchitis
___ Emphysema
___ Pneumonia
Type: _____
___ Tuberculosis

## Reproductive

___ Sex. Trans. Dis.
Type: _____
___ Endometriosis
___ Pregnancies (#)
___ ('C' if current)
___ Miscarriages (#)
___ Abortion (#)

## Digestion

___ Constipation (Chronic)
___ Diabetes
___ Diarrhea (Chronic)
___ Gastritis
___ Gall Stones
___ Hepatitis
___ Hypoglycemia
___ Jaundice
___ Liver Disorder
___ Ulcers

Other _____