CLIENT INTAKE FORM

Name ____ Date of Birth ______________

Address ____

City, State, Zip ____

Phone (Hm) ____________________ Wk ________________ Cell _______________

Email ____

Occupation _________________________ Employer ____________________________

Relationship Status ______________Children/ages? ___________________________

Referred By ____

Reason for Today's Visit ____

What are your goals/ expectations from this healing today? Long range?

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____

What do you see as recurring issues (physical, emotional) in your life?

____

____

Have you had experience with complementary/ alternative therapies? If so,

What are they? ____

Physician (name, phone) ____

Antibiotics/ Medications Currently Taken ____________________________________

Non-Prescription Drugs/Supplements Currently Taken ________________________

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Alcohol Intake? ____________________ Tobacco/ Cigarettes? ___________________

General Type of Diet ____

Do you exercise? What type? ____

Accidents/ Injuries ____

Surgeries/Hospitalizations ____

In case of Emergency, please contact: Name: ____________________________

Phone: ____________________________Relationship to you: ________________________

Do you have or have you had: (Please mark "C" to indicate current symptoms or "P" for symptoms you have had in the past.)

__Constipation	__Back Pain	__Fungal Infections	__Rheumatic Fever	__AIDS
__Diarrhea	__Hypertension	__Bronchitis	__Fever	__Hypoglycemia
__Depression	__Emphysema	__Malaria	__Cancer	__Heart Disease
__Indigestion	__Mood Swings	__Pleurisy	__Mononucleosis	__Stroke
__Gastritis	__Insomnia	__Pneumonia	__Tuberculosis	__Pancreas Problems
__Epilepsy	__Fatigue	__Chicken Pox	__Rheumatism	__Liver Problems
__Dizziness	__Ulcers	__Measles	__Arthritis	__Kidney Problems
__Migraines	__Allergies	__German Measles	__Diabetes	__Syphilis
__Headaches	__Eczema	__Mumps	__Herpes Simplex 1	
__Earaches	__Psoriasis	__Whooping Cough	__Herpes Simplex II	
__Jaw Pain	__Jaundice	__Gonorrhea	__Female Organ Problems	

Is there anything else you would like to share?