

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:

Client Signature: _____ Date: _____

Client Health Intake Form

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