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: highlight or circle

headaches	allergies	arthritis, tendonitis
cancer	TMJ	abnormal skin conditions
heart/circulation problems	joint surgery	high/low blood pressure Drs Care? y or n
major accident	varicose veins	blood clots
neck/back injuries	diabetes	fibromyalgia
numbness	sprains, strains	recent injuries

Explain any condition you have marked above:

_____

_____

_____

Contract for care: I promise to participate fully as a member of my health care team. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I understand any information obtained via medical intuition or spiritual guidance or via professional opinion should always be verified by a Doctor or Naturopath. It is only for suggestion purposes only, not meant to cure, treat or prescribe.

Consent for care: It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Client Signature:_____ Date:_____

Parent or Guardian signature if under 18:_____ Date:_____

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