CLIENT INTAKE FORM / CONFIDENTIAL (for practitioner's use only)
(Please write or print clearly)

Name _____ Date of Visit _____
Address
_____
_____
Phone: Home _____ Work _____ Cell _____
E-mail Address _____
Referred by _____ Occupation _____
Relationship Status _____ # Children ____
D.O.B. _____ Height _____ Weight _____
Emergency Contact (name & phone)
_____
Physician (name, phone)
_____
Therapist (name, phone)
_____
Reason for Visit
_____
_____ Date of Onset _____ Sudden ____ Slow _____
Current / Previous treatment
_____
_____
Current Medications
_____
Current Complementary Therapies / Supplements
_____
Eating Habits / Diet
_____
Daily Intake: Water _____ Caffeine _____ Alcohol _____ Cigarettes / Tobacco _____
Exercise Routine
_____

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for Past, and 'CH' for chronic. - Explain if necessary.

EMOTIONAL/PSYCH	Pituitary Dysf.	CARDIOVASCULAR	Jaundice
Depression	Hyperthyroid	Angina	Liver Disorder
Eating Disorder	Hypothyroid	Heart Attack	Ulcers
Mood Swings	NEUROLOGICAL	Heart Failure	URINARY
Substance Abuse (type)	Epilepsy	Hypertension	Bladder Infection
AUTO-IMMUNE	Dizziness	Stroke	Kidney Stones
Aids / HIV	Insomnia	RESPIRATORY	REPRODUCTIVE
Allergies	Migraines	Bronchitis	Sex. Trans. Dis. (type)
Cancer	MUSCULO-SKELETAL	Emphysema	Endometriosis
Fatigue	Arthritis	Pneumonia	Pregnancies (# & 'C')
Fever (chronic)	Back Pain	Tuberculosis	Miscarriage (#)
Fibromyalgia	Carpal Tunnel	DIGESTION	Abortion (#)
Fungal Infections (type)	Gout	Constipation (chronic)	
Herpes (type)	Skin Disorder (type)	Diabetes	OTHER:
Lyme Disease	ENT	Diarrhea (chronic)	
Mononucleosis	Earaches (chronic)	Gastritis	
ENDOCRINE	Headaches	Hepatitis	
Adrenal Insuf.	Jaw Pain	Hypoglycemia	

PLEASE CONTINUE

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, and 'CH' for chronic.

Crying Spells	Change in Sleep	Family Problems	Angry outbursts	Loneliness
Relationship Problems	Increased nervousness	Eating changes	Social problems	Seeing things
Headaches	Work problems	Trouble concentrating	Sadness	Hearing things
Change in sexual activity	Suicidal	Feeling out of control	Homicidal	Unmotivated
Loss of trust in others	Financial problems	Panic attacks	Weight loss / gain	
Forgetfulness	Violent feelings	Increased alcohol / drug use	Confusion	

Please list any injuries you had and have:

_____
_____
_____
_____

Please list any surgeries you had or know you will have:

_____
_____
_____
_____

Please list any traumatic or life threatening events that occurred in your life, and when they happened:

_____
_____
_____
_____

What are your goals / expectations from this session today? Long-term?

_____
_____
_____
_____

Is there anything else you want to share or want me to know?

_____
_____
_____
_____