Client Intake Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Home Number _____ Cell Number_____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

Have you had any major or minor surgical procedure or injury? ____ Yes ____ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, Psychologist or Physician for an ongoing issue?

____ Yes ____No

Please Explain:

Please rate your stress level Rate your pain level 1=no pain, 10=worst pain ever

Low 1 2 3 4 5 High 1 2 3 4 5 6 7 8 9 10

Any known allergies? ____ Yes ____ No

Please Explain: _____

Intake Form

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/Fractured bones
- ☐ Strains/Sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis

Other:_____

Circulator/Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Stroke

- ☐ Heart condition
- ☐ Allergies
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure

Other:_____

Digestive

- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis

Other:_____

Nervous System

- ☐ Numbness/tingling
- ☐ Fatigue
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease

Other:_____

Reproductive System

- ☐ Pregnancy
- ☐ Ectopic Pregnancy
- ☐ Hysterectomy
- ☐ Prostate

Other:_____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Acne
- ☐ Impetigo
- ☐ Hemophilia

Other

- ☐ Loss of Appetite
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Tuberculosis

Other:_____

Doctor's Diagnosis

_____

_____

_____

_____

_____

_____ _____

Client Signature Client Printed Name

_____

Date

_____ _____

Practitioner's Signature Practitioner's Printed Name

_____

Date