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:

☐ headaches	☐ allergies	☐ arthritis, tendonitis
☐ cancer	☐ TMJ	☐ abnormal skin condition
☐ heart/circulation problems	☐ joint surgery	☐ high / low blood pressure
☐ major accident	☐ varicose veins	☐ blood clots
☐ neck / back injuries	☐ diabetes	☐ fibromyalgia
☐ numbness	☐ sprains, strains	☐ recent injuries

Explain Any Conditions You Have Marked Above:

_____

_____

_____

_____

Client Signature: _____**Date:** _____