CLIENT INTAKE FORM

Full Name: _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Email: _____

Emergency Contact: _____ **Phone:** _____

Relationship: _____

Physician: _____ **Phone:** _____

Significant Health Conditions: _____

Medications Being Taken: _____

Please indicate any of the following conditions that you currently have:

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

Explain Any Conditions You Have Marked Above:

_____

_____

_____

_____

Signature: _____ **Date:** _____