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Client Intake Form

Name _____ Date ___/___/___ DOB___/___/___

Address_____ Phone_____

Email_____ Referred by_____ DOI ___/___/___

Occupation _____ How long? _____

Insurance Co. address_____

Phone #_____ Claim # _____

Reason for today's visit:_____

Area of pain/concern_____ Onset _____

Symptoms and intensity_____

Your Birth Order: ☐ First born; ☐ Second; ☐ Third; ☐ _____; ☐ Only child; ☐ Vaginal birth ☐ C Section

Medications_____

(list on back if necessary)

Recent stress level_____

Goals of treatment _____

Medical History: Please give details on the back

☐ Allergies	☐ Arteriosclerosis	☐ Atherosclerosis	☐ Arthritis	☐ BP High/Low
☐ Bruising	☐ Bursitis	☐ Bowel Issues	☐ Cancer	☐ Chronic Fatigue
☐ Concussion	☐ Diabetes	☐ Disc Problems	☐ Falls	☐ Fibromyalgia
☐ Fractures	☐ Gastritis	☐ Headaches	☐ Heart Issues	☐ Herpes
☐ Immune Disorder	☐ Infection	☐ Joint Issues	☐ Kidney Disorder	☐ Liver Disorder
☐ MS	☐ Neural Disorder	☐ Osteoporosis	☐ Pain	☐ Parkinson's
☐ PMS	☐ Pregnant	☐ Have given birth	☐ Respiratory	☐ Reynaud's
☐ Seizures	☐ Skin Condition	☐ Sprain/Strain	☐ Surgeries	☐ Varicose Veins
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____

Nurturing touch may activate memories of past experiences, including trauma and abuse. Please let me know at your first visit if you have a history of these so we can discuss your comfort boundary in dealing with them should they arise.

To assure optimal care I may need to communicate with your other care providers. Have I your permission to do so? ☐ Yes ☐ No

Provider _____ Phone _____

Signature_____ Date _____/_____/_____