



CLIENT INTAKE FORM

First, Middle, Last Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/Zip _____ Date of Birth: _____ Age _____

Referred by: _____ Marital Status _____

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

Health Insurance : _____ Primary Physician: _____

Health Ins. Number: _____ Group Num.: _____

Secondary Ins.: _____ Ins. Num.: _____

Health/Medical History:

Are you seeing a health care professional? Yes/No-List reason _____

Date of last checkup: _____

Are you taking prescribe medications and/or _____

Over the counter, vitamins? Yes/No-List _____

Any Known Allergies? Yes/No-List _____

Are you experiencing, or have you been diagnosis for any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Anemia's/Blood Disorder |
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Chronic Sinus conditions |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Nerve/Neuritis Disorders |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Arthritis/Tendonitis | <input type="checkbox"/> Kidney/Bladder Conditions |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Liver/Gall Bladder Disorder |
| <input type="checkbox"/> Cut/Bruises | <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> Chronic Respiratory Condition |
| <input type="checkbox"/> Strokes/TIA | <input type="checkbox"/> Lymphatic Conditions | <input type="checkbox"/> Reproductive Conditions |
| <input type="checkbox"/> Heart Diseases | <input type="checkbox"/> New Tattoos/Piercing | <input type="checkbox"/> Contagious Conditions |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Disc Disorders |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Warts/Skin Conditions | <input type="checkbox"/> Muscular/Skeletal Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Burns/Sunburns | <input type="checkbox"/> Diabetes/Low Blood Sugar |

Any pain, numbness, or tingling anywhere or other diseases or disorders not listed? _____

MT use only: _____