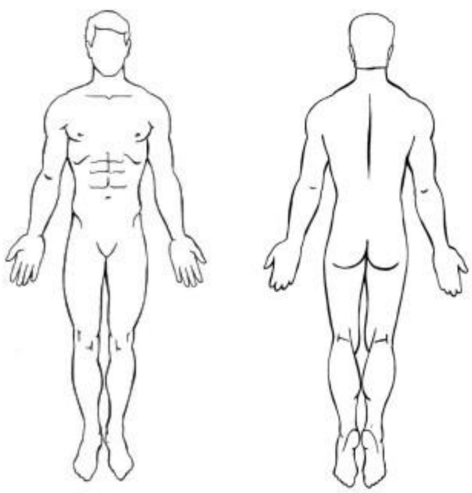
New Client Intake Form

Name: ______________________________________ Date: ______ Referred By: ___________________
Address: ____________________________________ Phone – Work: ______________________________
City/State/Zip: ______________________________ Phone – Home: ______________________________
Birthday: ___________________________________ Mobile: _____________________________________
Occupation: _________________________________ E-Mail: _____________________________________
Emergency Contact: ___________________________ Phone: ______________________________________

General Information:

What is your main reason for coming to therapy? ____
What specific goals would you like to achieve from therapy? ____
____
How and when did the symptoms begin? ____
Where are your symptoms located? Please mark the areas on the figures below:



How long have you had these symptoms? ____
Are you currently, or have you ever been, under medical supervision for this problem? _____________________
____
Have you had any tests for this problem; such as x-rays, MRI or CT scans? ___________________________________
Describe the symptoms. Please check all that apply:
□ Dull □ Ache □ Burning □ Sharp □ Periodic □ Constant □ Sore □ Stiff □ Numb □ Tingling
What makes it better or worse? ____
____
On a scale of 0 to 10 with 10 being the most severe imaginable discomfort, what is your discomfort level right now? ____
What time of day is the pain worse? ____
Do you have trouble sleeping? If yes, what position do you sleep in? ___________________________________

Physical Factors:

What physical activities are you currently involved in? ____
Do you stretch now? ____
Do you feel flexibility is an important part of fitness? ____
Have you ever had chiropractic treatment? If yes, how long, how often and with whom? ____________________

Have you ever seen a Naturopathic doctor? ____

Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If yes, what type? ______

Do you wear any type of supportive braces anywhere? ____

Do you wear orthotics? __________ If yes, for how long? ____

What percentage of your day is spent sitting? __________, standing? ___________, driving? _____________

Are your symptoms worse at the end of the workday? ____

Does your work station give you support and encourage good posture? _______________________________

How would you rate your own posture? ____

Medical History

Please list any recent injuries, illnesses, or surgeries: ____

____

____

Are you currently under the care of a physician? Yes________ No________

If yes, please explain.

____

List current medications, including aspirin, ibuprofen, etc. ____

____

Please check all that apply

____	Cancer	____	Hi/Low Blood Pressure	____	Epilepsy
____	Digestion Problems	____	Elimination Problems	____	Ulcers
____	Cancer: Type _____	____	Respiratory Problems	____	Cold Hands/Feet
____	Migraines/Headaches	____	Sinus Problems	____	Heart Problems
____	Back Problems	____	Neck Problems	____	Bruise Easily
____	Sciatica	____	Arthritis/Bursitis	____	Allergies
____	Stroke	____	Immune Disorder	____	Fibromyalgia
____	Scoliosis	____	TMJ	____	Carpal Tunnel
____	Osteoporosis	____	Tendonitis	____	Asthma
____	Diabetes	____	Now Pregnant	____	Immovable Joints

Do you have any chronic or frequent pain? ____

Have you had any accidents, auto or other? ____

Have you ever had any major surgeries? ____

Have you ever had a head injury? _________ Have you noticed dizziness? ______ Change in hearing? _______

Change in vision?_____________

Are there any other medical conditions the therapist should be aware of? ______________________________

Are you pregnant? _____ If yes, how far along are you? ____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person here that I'm seeing of my condition. I understand that this office does not diagnose or treat illness or disease and does not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Emergency cancellations will be determined by owner. It is agreed that any claim of liability is hereby waived.

______________________________________ ______________________________________

Signature Date