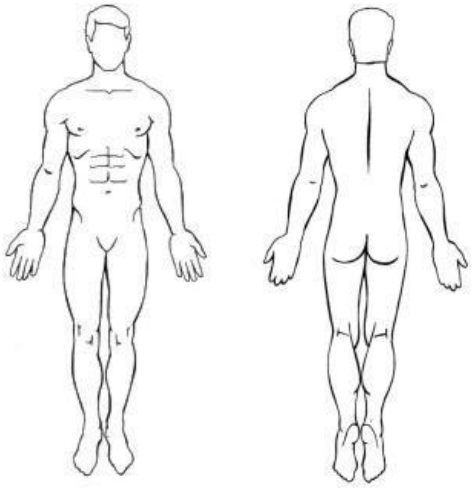
New Client Intake Form

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