

# Client Intake Form

## PERSONAL

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Military Service \_\_\_\_\_

Marital Status \_\_\_\_\_ Name of Spouse / Significant Other \_\_\_\_\_

Children # \_\_\_\_\_ Ages \_\_\_\_\_ Parents (living) \_\_\_\_\_

Other family information \_\_\_\_\_

## EDUCATION

Last School Attended \_\_\_\_\_

Grade Completed \_\_\_\_\_ College Years Completed \_\_\_\_\_ Major \_\_\_\_\_

## MEDICAL HISTORY (circle)

Diabetes      Alcoholism      Addiction      Fibromyalgia      Migraines      IBS      Insomnia

High Blood Pressure      Asthma      Heart Trouble      Erectile Dysfunction      Anxiety      Depression

**List ALL current prescription medications** \_\_\_\_\_

\_\_\_\_\_

**Habits**      Alcohol      Tobacco      Coffee/Tea      Special Diet

Other \_\_\_\_\_

Family Physician \_\_\_\_\_

**May we contact your physician and update them on your progress? (circle) YES NO Initials**

Are you in good general health? Yes \_\_\_\_\_ No-describe \_\_\_\_\_

Are you presently in any discomfort? Yes-describe \_\_\_\_\_ No

**Purpose of today's visit? (circle)**      Smoking Cessation      Weight Loss      Stress Management

Sleep Issues      IBS      Migraines      Other \_\_\_\_\_

**How did you hear about us:** Radio-station \_\_\_\_\_, Yellow Pages, Referral from \_\_\_\_\_

Other \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_