



Confidential Health Intake Form

Name _____ Date of Birth _____
Street Address _____ City _____
State _____ Zip _____ Home Phone _____ Cell _____
Emergency Contact _____
Email _____ Referring Physician _____
Primary Care Physician _____

Medical History and Information

Check any or all that apply to your present health:

- | | | |
|--|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chronic pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> sprains/strains/dislocations | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis/lordosis/kyphosis | <input type="checkbox"/> cancer/tumors |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> chemo/radiation | <input type="checkbox"/> kidney disease | <input type="checkbox"/> lupus |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> fibromyalgia syndrome | <input type="checkbox"/> heart attack/stroke |
| <input type="checkbox"/> seizures | <input type="checkbox"/> cortisone injection | <input type="checkbox"/> allergies |

Women only: pregnant painful menstruation endometriosis

If pregnant, what trimester/week are you in? _____

Men only: Prostrate problems

List all medications/herbs/vitamins:

List physical activities you participate in _____

What movements or activities are limited?

Describe the events of the injury or accident:

List previous major injuries/surgeries:

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic):

What seems to help the most?

What seems to aggravate the condition the most?

What is your main activity at work? On phone _____ Sitting_____ Computer work_____

Driving car_____ Walking_____

Other _____

What do you do to relieve stress?

What do you want to get out of you session (s)?

Practitioner Comments

Client's Signature: _____ Date: _____