

Client Intake Form

Please fill out the form below. Fields marked with * are required.

Basic Information

First Name *

Last Name *

Date of Birth *

 

Gender

 

Occupation

Contact Information

Email *

Phone (mobile preferred) *

Address

City

State

Zip

Cell

Emergency Contact Information

Contact Name *

Phone *

Relationship

Referral & Physician

How did you hear about us?

Physician Name (optional)

Physician Phone

Additional Questions

Have you ever had any injuries to your head? Concussion or TBI?

If yes, how long ago? Are you still being treated?

Are you currently seeing a mental health professional?

If so, what are they treating you for?

Have you ever had physical or psychological trauma?

If yes, have you been diagnosed with PTSD, CPTSD, Bipolar, Anxiety, Depression, DID or other?

Are you currently being treated by a doctor or physical therapist?

If so, please state below.

Medical History (check all that apply)

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Shortness of Breath
- Chronic cough

Cardiovascular

- Blood Clots
- Pacemaker
- Stroke
- High Blood Pressure
- Heart Attack
- Varicose Veins

Skin

- Bruise Easily
- Melanoma
- Skin Irritations
- Hypersensitive Reaction

Head & Neck

- Migraines
- Headaches
- Sinus Problems
- Hearing Loss
- Vision Loss
- Jaw Pain (TMJD)

Infectious Conditions

Hepatitis

HIV

Women

Gynecological Conditions

Herpes

Athlete's Foot

Pregnancy

Soft Tissue / Joint Dysfunction

Ankles (Left)

Knees (Right)

Lower Back (Left)

Shoulders (Right)

Hips (Left)

Feet (Right)

Family History & Misc

Cardiovascular Conditions

Respiratory Conditions

Allergies

Cancer

Dizziness

Insomnia

Other Information

Notes / Additional Information

Reset

Submit