CLIENT INTAKE FORM

(Strictly Confidential)

Name _____ Date _____

Address _____ City/St/Zip _____

Phone _____ Email _____

Preferred Contact Method: Text☐Call☐Email☐ Marital Status _____

Children (ages) _____ Siblings _____

Occupation _____ Employer _____

List your major challenges you'd like to overcome in order of importance to you, and how long you have been experiencing each one:

1. _____
2. _____
3. _____
4. _____

List 4 things you want more of in your life:

1. _____
2. _____
3. _____
4. _____

If you have health challenges, what are they? _____

If so, what are the most contributing factors? (Diet, lifestyle, relationships, stress (topic), finances, work—Rank in order.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you under the care of a physician and if so, what for? _____

_____

Are you currently of have you in the past used services of a chiropractor, acupuncturist, holistic health or nutritional consultant? _____

List any current medications you are currently taking and how long: _____

_____

_____

If true, finish this sentence: "I have not been well since".... _____

Do you have pain in any part of your body? If so where, and how long? _____

_____

Have you had any of the following: surgeries, shocks, traumas, injuries, falls, abuse?

_____

_____

_____

Do you consume any of the following? If yes, indicate how much:

Alcohol _____ Cigarettes _____

Coffee _____ Recreational Drugs _____

On a scale of 1-10, how committed are you to addressing your Problem/Pain/Issue/Symptom? _____

Who were you closest to growing up? _____

What part did they play? _____

_____