CLIENT INTAKE FORM

PERSONAL INFORMATION

Full Name_____ DOB: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _____Email: _____

Occupation: _____

Emergency Contact: _____ Phone # _____

Relationship: _____

MEDICAL HISTORY

Health Conditions: _____

Health Conditions: _____

Health Conditions: _____

Medications:_____

Medications:_____

Medications: _____

Medications:_____

Please indicate any of the following conditions that you currently have:

☐**Headaches** ☐**Allergies** ☐ **Recent Injuries: _____**

☐**Cancer** ☐**TMJ**

☐**Heart/Circulation problems** ☐**Joint Surgery**

☐**Neck/ back injuries** ☐**Varicose Veins**

☐**Numbness** ☐**Diabetes**

CLIENT INTAKE FORM

TYPE OF PROCEDURE YOU ARE HAVING

_____

PLEASE LIST DOCTORS NAME, PHONE NUMBER AND ADDRESS

_____

_____

ADDRESS AND LOCATION OF SURGICAL PROCEDURE

Client Name: _____

Client Signature: _____