INTAKE FORM

(Use of the information provided below is for the safety and care of the client while services are rendered and will be kept strictly PRIVATE and CONFIDENTIAL)

BY CLIENT **TODAY'S DATE:** _____ Date of Birth ___/___/_____

Name: _____ Phone: _____ Email: _____

Address: _____ City _____ State ___ Zip _____ || Occupation _____

Emergency Contact (Name): _____ Relationship _____ Phone _____

Who Referred You: _____ OR

Where did you learn about ABC: _____

Primary Reason for Visit: _____

_____

Describe When and Where Symptoms Occur(ed): _____

_____

DO YOU HAVE...please DESCRIBE; or provide DIAGNOSIS:

__ High/Low Blood Pressure	__ Diabetes _____	__ Migraines; Frequency _____
__ Cardiovascular Disease	__ Infections _____	__ Depression; Treated? _____
__ Varicose veins/circulatory issues	__ Skin Condition _____	__ Disorders _____
__ Osteoporosis _____	__ Allergies _____	__ Pain _____
__ Fractures/Dislocations _____	__ Cancer _____	__ _____
__ Disc/spinal injury/pain _____	__ Surgery _____	__ _____
__ Arthritis _____	__ Stroke _____	__ _____

Condition(s) not mentioned: _____

Treatments Received for any of the above: _____

_____

Medications (now/before) related to visit: _____

_____

General Health (check): Excellent__ Good__ Fair__ Poor__

Physical Exercise: (i.e. Daily/30min/Moderate): _____

Pregnant? _____ Weeks? _____

BY PRACTITIONER

_____(date/initial)

_____(date/initial)

_____(date/initial)

_____(date/initial)

_____(date/initial)

_____(date/initial)

_____(date/initial)

_____(date/initial)

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