## SAMPLE INTAKE FORM

Name:

Date:

Address:

City, State, Zipcode:

Mobile: Home: Work:

Email: Date of Birth:

Occupation/Employer:

Referred By:

How would you rate your present state of health? Excellent Good Fair Poor

Reason for your visit?

Please list any current injury/illness/surgery and/or chronic conditions.

Please list any past injury/illness/surgery.

What, if any, psychiatric or health concerns are you currently receiving treatment for? List any medications.

Please list any holistic therapies you’re participating in.

Where does your body hold tension? (e.g. neck, shoulders, stomach)

Please list any additional comments regarding your health and well-being.