CLIENT INTAKE FORM

Name_____ Date of Visit_____

Address_____

_____

Date of Birth_____ Height_____ Weight _____

Occupation_____ Work Phone_____ Home Phone_____

Relationship Status_____ Children_____ Referred By_____

Therapist (name, address, phone)_____

_____

Physician (name, address, phone)_____

_____

Therapeutic/Spiritual Growth Experience_____

_____

Reason for Visit_____

_____

Date of Onset_____ Sudden ____ Slow____

Previous Treatment_____

_____

Antibiotics/Medications Currently Taken_____

Non-Medicinal Drugs Currently Taken_____

Alcohol Intake_____ Tobacco/Cigarettes_____ Daily Fluid Intake (Not Alcohol)_____

General Type of Diet_____

Exercise_____

Vision_____ Wear Glasses/Contacts_____ Smell_____ Hearing_____ Taste_____

Accidents/Injuries_____

Surgeries_____

Do you have or have you had: (Please mark "C" to indicate current symptoms or "P" for symptoms you have had in the past.)

___Constipation	___Back Pain	___Fungal Infections	___Rheumatic Fever	___Syphilis
___Diarrhea	___Hypertension	___Bronchitis	___Fever	___Heart Disease
___Flatulence	___Depression	___Emphysema	___Malaria	___Cancer
___Indigestion	___Mood Swings	___Pleurisy	___Mononucleosis	___Epilepsy
___Gastritis	___Insomnia	___Pneumonia	___Tuberculosis	___Stroke
___Dysentery	___Fatigue	___Chicken Pox	___Rheumatism	___Female Organ Problems
___Dizziness	___Ulcers	___Measles	___Arthritis	___Pancreas Problems
___Migraines	___Allergies	___German Measles	___Diabetes	___Liver Problems
___Headaches	___Eczema	___Mumps	___Herpes Simplex I	___Kidney Problems
___Earaches	___Psoriasis	___Whooping Cough	___Herpes Simplex II	___AIDS
___Jaw Pain	___Dandruff	___Jaundice	___Gonorrhea	___Hypoglycemia

What are your goals/expectations from this healing today? Long range?

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