**CLIENT INTAKE FORM**

**Private and Confidential**

|  |  |
| --- | --- |
| Name: | Date: |
| Address: | Birth Date: |
| Phone: | Referred By: |
| Emergency Contact: | Male / Female |
| E-mail: | Occupation: |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| Health Care Provider: | Please list any medications you are taking (should include herbs, vitamins and dosages): |
| Date of Last Physical: |  |

Please check any or all that apply to your current health:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Headache/migraines |  | Chronic pain |  | Varicose veins |
|  | Vision problems |  | Muscle or joint pain |  | Blood clots |
|  | Sinus problems |  | Numbness/tingling |  | High/low blood pressure |
|  | Jaw pain/teeth grinding |  | Sprains/strains |  | Diabetes |
|  | Fatigue |  | Scoliosis |  | Cancer/tumors |
|  | Depression |  | Arthritis |  | Infectious disease |
|  | Sleep difficulties |  | tendonitis |  | Skin problems |

Women only: \_\_\_\_Pregnant \_\_\_\_Painful menstruation \_\_\_\_Endometriosis

Men only: \_\_\_\_Prostrate problems \_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of any disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received professional bodywork in the past including chiropractic or osteopathic care? If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever suffered any serious injuries or trauma, been hospitalized or had surgery in past 5 years? Please briefly describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The human body functions as a whole, no one part can be separated from the other. Whenever possible, I try to work on all areas to get the best possible results.

**CONSENT FOR CARE**

I release Sandra Roy for any and all liability from problems arising from the treatment. I hereby agree that it is my responsibility to keep my therapist Sandra Roy properly informed of any changes in my state of health. It is my choice to receive treatment. I am aware of the benefits and risks and I give my consent to receive treatment. I understand that the client/therapist relationship will be held in strict confidence.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian if under 18 years of age)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_