## **Client Intake Form**

Name:	Date:
Please answer the following qu	
1. Home Address:	
	Email:
	Age:
4. Occupation / Activities:	
5. How did you hear about us?	
6. List your goals	
7. Describe the challenge for wh	nich you are seeking assistance:
	,
8. How long have you had this?	?
9 Are you having pain now? If	so, where? what is the intensity? 10 being the worst?
	50, where. What is the interiory. To being the Worst.
10. Please briefly state past mod	lical history including surgeries and assidents.
To. Flease offerry state past flec	lical history including surgeries and accidents:

11. Describe your living situation? (partner, alone, with parents, children, pets)
12. What Supplements, Substances, or Medications are you on?
13. What health care professionals are you currently seeing?
14. How do you relax?
15. How many hours do you sleep and is it restful?
16. Any other information you would like to include that you feel will be helpful?
Please Bring This Form Filled Out To Your First Session