New Client Intake Form

Date

Name (Last, First, MI) | Date of Birth

Gender | *Marital Status* | *Occupation* | *Social Security #*

Home Address (Street, City, State and Zip) | *Phone#* | *Email Address*

Emergency Contact Name and Relationship | *Phone #*

Primary Care Physician Name | *Phone #*

Referring Doctor, if applicable | *Phone #*

1st Insurance Company and Policy # | *2nd Insurance Company and Policy #*

MEDICATIONS

Please list all medications, vitamins, minerals, & supplements that you are taking, including the dose.
(If additional space is needed, please include separate sheet.)

MEDICAL HISTORY

Please check all that apply to your current situation.

- ☐ Anemia
- ☐ Anxiety
- ☐ Balance Issues
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea/Loose Stools
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol, High Triglycerides, High LDL / Low HDL (dyslipidemia)
- ☐ IBS
- ☐ Injury to Bones/Muscles
- ☐ Joint Disease
- ☐ Liver Disease
- ☐ Lung Disease, SOB, Asthma, Emphysema, COPD
- ☐ Memory Issues
- ☐ Osteoporosis
- ☐ Overweight
- ☐ Pre-Diabetes
- ☐ Recent Surgeries
- ☐ Stroke/TIA
- ☐ Thyroid Disorder
- ☐ Underweight
- ☐ Unexplained Mental Decline
- ☐ Unexplained Physical Decline
- ☐ Urinary/Kidney Disease

Current Height: _____ Current Weight: _____

List Allergies (medication, environmental, food, etc.)