

Client Intake Form

Name:

Address:

City:

State:

zipcode:

phone number:

Emergency contact:

Date of Birth:

Email:

Occupation:

*Are you currently seeing any other healthcare providers?
Whom/and for what reason?*

Medications:

Accidents/ falls (please include dates)?

Surgeries/ hospitalizations (please include dates)?

Frequent headaches (please explain)?

Any head, neck or back injuries?

Trauma (such as death, abuse etc.)?

Please share anything you know around your mother's pregnancy and birth....

Were you born at home or in a hospital?

Cesarean or vaginal delivery?

bottle or breast fed?

Was your mother under anesthesia?

More Details about your birth....