Client Intake Form

All information will be kept private and confidential

Date:

Date of birth:

First Name:

Last Name:

E-mail:

Phone:

Address:

Occupation:

Employer:

How Did you hear about BodyLogic Therapy?

What are your goals for this treatment?

Are you under medical treatment now?

◯ YES ◯ NO

If YES, what condition?

Please list your care providers name and phone number.
List any medications (including aspirin) and nutritional supplements you are currently taking:

Specify any known allergies:

How much water do you consume a day?

Nutrition (check one)

☐ Excellent ☐ Good
☐ Fair ☐ Poor

Exercise (check one)

☐ Excellent ☐ Good
☐ Fair ☐ Poor

Are you pregnant?

◯ YES ◯ NO

If you are pregnant what trimester?

Health History

Check the following conditions that apply to you, present or past. Please add any comments for clarity below.

- ☐ allergies
- ☐ athletes foot
- ☐ back or hip pain
- ☐ blood clots
- ☐ chronic fatigue syndrome
- ☐ depression / anxiety
- ☐ diabetes
- ☐ eating disorder
- ☐ fibromyalgia
- ☐ heart condition
- ☐ headaches
- ☐ high / low blood pressure
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ jaw pain / TMJ
- ☐ joint stiffness / swelling
- ☐ migraines
- ☐ osteoporosis
- ☐ scoliosis
- ☐ shoulder / neck /arm /hand pain
- ☐ sinus problems
- ☐ spasms, cramps
- ☐ swollen ankles

Cancer?

◯ YES ◯ NO

If YES where?

Infectious Disease?

◯ YES ◯ NO

If YES where and when?

I agree that the above information is true and accurate to the best of my knowledge. I will inform my therapist
of any changes in my status.

☐ AGREE

Please print and sign this form to bring with you on your first visit to BodyLogic Therapy.