

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.