CLIENT INTAKE FORM

Confidential Client History

Please Print

Date: _____ **Home #:** _____

Name: _____ **Work #:** _____

Address: _____ **Date of Birth:** _____

City, State, Zip Code: _____

Occupation: _____ **Referred By:** _____

What is your major complaint? _____

What changes have you noticed with your body? _____

List medications: _____

Any organs or parts removed? _____

Have you ever had or been diagnosed as having problems with any of the following:

[ ]	**Anemia**	[ ]	**Kidneys**	[ ]	**Hypoglycemia**	[ ]	**Weight**
[ ]	**Cancer**	[ ]	**Fainting**	[ ]	**Bleeding**	[ ]	**Allergies**
[ ]	**Diabetes**	[ ]	**Menopause**	[ ]	**Lungs**	[ ]	**Throat**
[ ]	**Prostate**	[ ]	**Ovaries**	[ ]	**Asthma**	[ ]	**Ulcers**
[ ]	**Heart**	[ ]	**Arthritis**	[ ]	**Hiatus Hernia**	[ ]	**Coffee**
[ ]	**Thyroid**	[ ]	**High/Low Blood Pressure**	[ ]	**Heart Burn**	[ ]	**Breast**
[ ]	**Skin/Acne**	[ ]	**Headaches**	[ ]	**Burping/Gas/Bloating**	[ ]	**Spleen**
[ ]	**Gallbladder**	[ ]	**PMS**	[ ]	**Edema**	[ ]	**Pancreas**
[ ]	**Fibromyalgia**	[ ]	**Numbness in hands/feet**	[ ]	**Weight**	[ ]	**Tumors**

If there are other aspects of your medical history of which we should be aware, please indicate:

_____

_____

Describe your normal meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please list your normal day's fluid intake:

Water	_____	**Alcohol**	_____
Coffee/Tea	_____	**Soda**	_____
Juice	_____	**Other**	_____

What type of water do you drink? _____

Patient's Signature: _____ **Date:** _____