**Confidential Client Case History and Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to plan the most effective session that is safe for you, I will need some general information about your health and medical wellness history. Please place an X in the box by any symptoms you are currently experiencing then rate your symptoms from 1 (hardly noticeable) to 10 (unbearable) adding any comments you feel would be helpful for me to know.

Primary Health Concerns

* Headache 1 2 3 4 5 6 7 8 9 10
* Heavy feeling in limbs 1 2 3 4 5 6 7 8 9 10
* Cold in hands and feet 1 2 3 4 5 6 7 8 9 10
* Faintness/Dizziness 1 2 3 4 5 6 7 8 9 10
* Vision
	+ Blurry 1 2 3 4 5 6 7 8 9 10
	+ Peripheral 1 2 3 4 5 6 7 8 9 10
	+ “Snow” 1 2 3 4 5 6 7 8 9 10
	+ Right Side 1 2 3 4 5 6 7 8 9 10
	+ Left Side 1 2 3 4 5 6 7 8 9 10
* Back pain
	+ Lower 1 2 3 4 5 6 7 8 9 10
	+ Middle 1 2 3 4 5 6 7 8 9 10
	+ Upper 1 2 3 4 5 6 7 8 9 10
	+ Right Side 1 2 3 4 5 6 7 8 9 10
	+ Left Side 1 2 3 4 5 6 7 8 9 10
* Jaw
	+ Tightness 1 2 3 4 5 6 7 8 9 10
	+ Clicking 1 2 3 4 5 6 7 8 9 10
	+ TMJ 1 2 3 4 5 6 7 8 9 10
	+ Grinding Teeth 1 2 3 4 5 6 7 8 9 10
* Bowel Issues:
	+ Constipation 1 2 3 4 5 6 7 8 9 10
	+ Loose Movements 1 2 3 4 5 6 7 8 9 10
	+ Irritable Bowel 1 2 3 4 5 6 7 8 9 10
* Shoulder/neck pain 1 2 3 4 5 6 7 8 9 10
* Weak body parts 1 2 3 4 5 6 7 8 9 10
* Carpel Tunnel Syndrome 1 2 3 4 5 6 7 8 9 10
* Addictions
	+ Smoking (#/day \_\_) 1 2 3 4 5 6 7 8 9 10
	+ Drinking 1 2 3 4 5 6 7 8 9 10
	+ Other 1 2 3 4 5 6 7 8 9 10
* Menstrual irregularities 1 2 3 4 5 6 7 8 9 10
* Nervousness/Anxiety 1 2 3 4 5 6 7 8 9 10
* Insomnia 1 2 3 4 5 6 7 8 9 10
* Fatigue 1 2 3 4 5 6 7 8 9 10
* Pains in heart/chest 1 2 3 4 5 6 7 8 9 10
* Poor appetite 1 2 3 4 5 6 7 8 9 10
* Excessive urination 1 2 3 4 5 6 7 8 9 10
* Are you pregnant? Yes No

****Other Medical Issues you feel I should be aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this, I affirm that I have stated all my known medical conditions and answered all questions honestly and to the best of my knowledge and that I will inform the practitioner of any changes in my condition(s) or medication(s). I understand that there shall be no liability on the practitioner’s part should I fail to do so. By signing this I agree to the terms found in the Policies and Procedures.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_