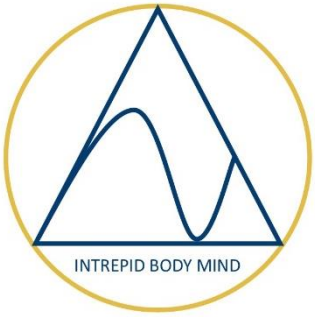


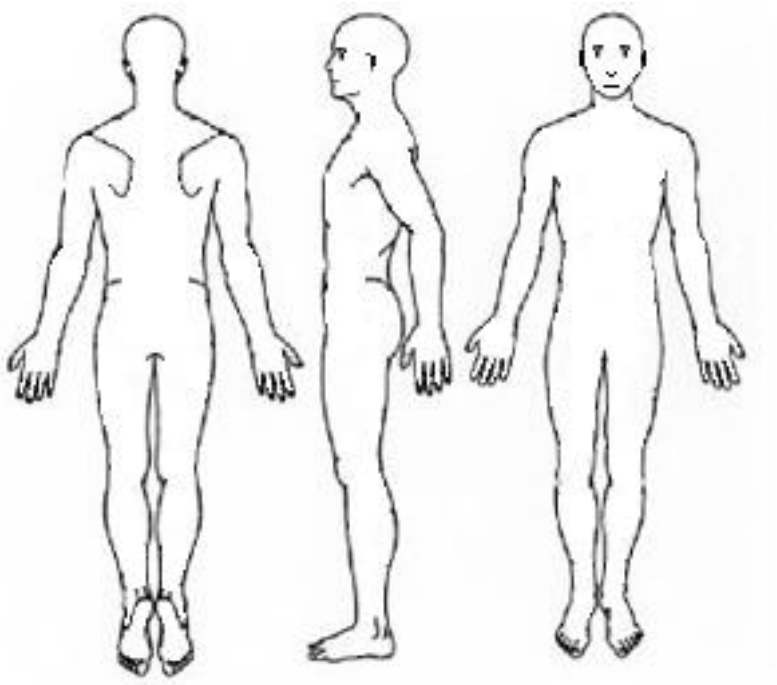
New Client Intake Form

Name:
Date of Birth:
Email Address:
What are your goals for the treatment session?
What are your overall goals for health: Physical: Mental: Emotional:

List your current health concerns including the approximate date of onset
How have these concerns been influencing your daily life and activities?
List previous and ongoing treatments and/or diagnostic testing:
List any medications or supplements that you are currently taking:
Describe your current exercise or movement routine including how often you exercise or move your body:
How many hours of sleep do you get per night?
Please rate the following on a scale of 1 – 10 (1 = poor, 10 = excellent) Quality of Sleep: Energy Level: Joy in life: Stress Level:

Please outline the nature of any stress that you may have in your life:

If you have any pain in your body, please indicate the location by drawing on the diagram, and give that pain a grade on a scale of 1 – 10. (1 = awareness, 10 = extreme)



What types of activities would you like to do more of once this is no longer a concern?

When do you feel at your best physically, mentally, emotionally and/or spiritually?

Can you remember a time in your life when you would have described your state of health as a 10? If so, what words would you use to describe what that felt like?

If you could have one goal that you would like to focus on achieving once your health is restored, what would that goal be?

Client Signature: _____

Date: _____