

Client Intake Assessment

Name: _____
Occupation: _____ Marital status: married /single /separated /divorced
Age: _____ Birth date: _____
Children: _____ Name / Ages: _____
Referred by: _____
Daily schedule / activities (general): _____

Diet: excellent / good / fair / poor
How much water do you drink? _____ Source? _____
Where did you grow up? _____
Physical stressors: _____

Emotional stressors: _____

Overall health: Excellent / good / fair / poor / other
Chief complaint (reason you are here): _____

Previous treatments for this complaint: _____

Other complaints or problems: _____

Current Medications / drugs being taken:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Are you currently under the care of a physician or other health care professional? Name, occupation:

1. _____
2. _____
3. _____
4. _____

Please list any surgeries, operations, traumas, car accidents, illnesses, or diagnosis:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Any family history of serious illnesses:

Any household pets or other animals you or family members are in close contact with:

Supplements, vitamins, herbs, homeopathic, you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

