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. __________________
2. __________________
3. __________________
4. __________________
5. ___________________
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. _______________________
2. _______________________
3. ____________________
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. ______________________
2. ______________________
3. ______________________
4. _________________
5. _________________
6. _________________