

## INTAKE FORM

Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Intention for coming?

Are you on any medications? \_\_\_\_\_ List all medications: \_\_\_\_\_

Are you currently under the care of any health care professional? \_\_\_\_\_

Please explain: \_\_\_\_\_

Do you frequently suffer from stress? \_\_\_\_\_

Do you experience frequent headaches? If so, please explain: \_\_\_\_\_

Have you ever been in an accident? Include dates: \_\_\_\_\_

Briefly detail any trauma occurrence in your life: death, accidents, attack, etc.: \_\_\_\_\_

Any falls? Include dates: \_\_\_\_\_

Any surgeries? Include dates: \_\_\_\_\_

Please share anything you know about your birth.

Were you born in a hospital? \_\_\_\_\_ or at home? \_\_\_\_\_ Was it a vaginal or caesarian delivery? \_\_\_\_\_

Was your mother under anesthesia? \_\_\_\_\_ Did you spend time in an incubator? \_\_\_\_\_ Were you breast-fed? \_\_\_\_\_

More details of your birth:

If there are any conditions not noted above, please indicate, using the back of the sheet.