

NEW CLIENT INTAKE FORM



First Name Last Name Date

Address City State Zip

Phone Work/Cell Phone

Email Age Height

Weight D.O.B. Occupation

Gender: M / F Marital Status: Married, Divorced, Widowed

Please tell us what your primary health concerns are:

Please list current medications you are taking:

Please list current supplements you are taking:

Please list any allergies:

Describe your health as a child:

Please describe your current level of physical activity and exercise

Have you ever received Bodywork? (Amma, Shiatsu, Swedish, Deep Tissue, etc...)

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Circle illnesses or conditions you have or had in the past:

Diabetes Glaucoma Heart trouble High blood pressure Syphilis Vein trouble Cancer
Asthma Jaundice Gonorrhea Bleeding tendencies Tuberculosis Mumps Pneumonia Allergies
Kidney disease Rheumatic fever Nervous disorder Measles Chicken pox HIV Meningitis
Multiple sclerosis Mononucleosis High fevers Antibiotic use Hepatitis Polio

Other: _____

List illnesses and date requiring surgery: _____

Any other serious injury, broken bones, scars, etc? _____

Are you pregnant? Yes / no How many months? _____

Are you currently receiving care from a: ___ Acupuncturist ___ Chiropractor ___ Dentist
 ___ Massage Therapist ___ Medical ___ Nutritionist ___ Physical Therapist

Circle illnesses which have occurred in any of your blood relatives:

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis Obesity Heart disease
High blood pressure Nervous illness Allergy Alcoholism Mental illness Stroke

Other: _____

COMMENTS (anything else you would like to tell us):

You understand that the practitioners of Pulse are not medical doctors and that the therapy and suggestions made are in no way meant to replace conventional medicine or treatment when and if necessary. _____
Initial

By signing below you acknowledge that you have been given the opportunity to review Pulse's posted Privacy Policy (HIPPA).

Signature

Date