Practice Member Intake Form

Practice Member Information

Name _____ **Email** _____

Phone (cell) _____ **DOB** _____ **Age** _____

Address _____ **City/State/Zip** _____

Emergency Contact Name _____ **Phone** _____ **Relation** _____

Occupation _____ **Referred by:** _____

Please check any areas you are having challenges:

- Head ☐
- Neck ☐
- Back ☐
- Shoulders ☐
- Legs ☐
- Hands ☐
- Feet ☐
- Teeth ☐
- Other ☐

Please check any that apply:

- Autoimmune disorder ☐
- Fibromyalgia ☐
- Heart Condition ☐
- Multople sclerosis ☐
- Neurological condition ☐
- Neuropathy ☐
- Sciatica ☐
- TMJ disorder ☐
- Vertigo/Dizziness ☐

Please list any other information you feel revelant:

_____

_____

_____

_____

_____

By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above Information changes at any time.

PRACTICE MEMBER SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____