Intake Form

Date

Full Name

DOB Male/Female

Address City

Unit Post Code

Email

Home Phone / Mobile

Occupation

Emergency Contact Name Emergency Contact Phone

Referred By

Have you had any complementary therapy treatments before? Y N
Please specify:

Are you currently under a physician's or other specialist's care? Y N

Physician's/Specialist's Name:
Physician's/Specialist's Contact:

Are you pregnant? Y N
If so, how many weeks? Please Specify:

Are you taking any medication/supplements? Y N
Please Specify:

Do you have any recent injuries? Y N
Please Specify:

Any surgeries? Y N
Please Specify:

Do you have allergies/sensitivities? Y N
Please Specify:

Reasons for seeking treatment

What areas of your life would you like to work with, i.e. overcoming health/physical/ mental/ emotional/spiritual issues, or setting and accomplishing goals etc?

Expectations for Seeking Treatment