Client Intake Form Date_____

Name_____
Date of birth_____Age_____
Address_____
City_____State_____Zipcode_____
Phone_____Cell_____
Email_____
Which is the best way to reach you_____
Would you like to receive our complimentary email newsletter_____

What are your goals for this visit_____
_____
_____
Prioritize your most important health concerns_____
_____
_____
What would you consider your current or chronic stressors_____
_____
_____

Would you describe yourself as experiencing any of the following recently or on a recurrent basis?

Fatigue_____
Sleep problems_____
Depression/Moodiness_____
Irritability_____
Memory Problems_____
Pain_____
Headache_____
Anxiety_____
Appetite/Weight Change_____
Other_____

Are you pregnant_____
Do you have a pacemaker_____
Do have any metal plates in your body_____