Intake form

Name____ Date________________

Adress________________________________City____________ ______Zip_________

Cell#_______________________ email:_______________________________________

Birthdate______________ Age________ Referred by__________________________

Marital Status _______________ Occupation ________________________________

Do you have a diagnosis by a physician? ______ What?______________________

What are your immediate issues you would like to address?____

Name of your Primary doctor___________________________ Number__________

Are taking medications? _______ What?____________________________________

What is your level of commitment to Lifestyle change? Strong Medium Weak

Do you take supplements? _____________ What brand?______________________

How much are you willing to spend on your health? ____________________________

Do you exercise? How much? What? _______________________________________

Do you smoke? ___________________ Do you drink?____________________________

Do you have children? _________ Ages? _________ are they healthy?____________

What issues do they have?_____________________ Are you under stress________

How did you find out about us?____

How would you like to pay today? Card Cash Check