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Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____ Gender ❑ M ❑ F Date _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone: ❑ Home _____ ❑ Work _____ ❑ Cell _____
(please indicate preferred contact number)

Occupation _____ Employer _____

Date of Birth _____ Age _____ Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Emergency contact _____ Relation _____

Emergency contact number: Home _____ Cell _____

Name of physician _____ Phone number _____
(No contact will be made without your permission)

Your signature _____

GOALS — What health concerns would you like to address through treatment

_____

_____

_____

_____

LIFESTYLE HABITS

Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____ Soda (regular or diet) _____

Cigarettes (packs per day) _____ Drug use (recreational) _____

Exercise ❑ Yes ❑ No How often? _____

What kind of exercise? _____