Intake form

Date: _____

Name: _____

Phone number: _____ Email: _____

Date of Birth: ____ / _____ / _____ (m/d/y) Occupation: _____ Years: _____

Referred by: _____

Chief complaint: _____

_____

Emergency contact: _____ Phone: _____

Family doctor: _____ Address / Phone: _____

Do you have difficulty with any of these? (Circle any)

Dizziness
Ringing in ears
Vertigo
Headaches
Earaches
Neck / Shoulder pain
Rheumatoid arthritis
Osteoarthritis
Joint pain
Osteoporosis / Osteopenia

High / Low blood pressure
Heart murmur / palpitations
Heart Disease
Pacemaker
Chest pain
Breathing issues
Shortness of breath
Chronic cough
Back pain (upper / mid / low)
Numbness (Arms / Hands / Legs / Feet)

Allergies (Seasonal / Food / Other)
Menstruation issues
Poor circulation
Varicose veins
Poor digestion
IBS
Constipation
Diarrhea
Hemorrhoids
Kidney / Bladder
Liver / Gallbladder

Sensitive Skin / Rashes
Eczema
Acne
HIV / AIDS
TB
Hepatitis
Diabetes
Fatigue
Thyroid trouble
Hormone imbalance

Medications, vitamins, other remedies: _____

_____

Surgeries, injuries, imaging: _____

Other healthcare: _____

Family medical history: _____

_____ # Children _____

Social behaviours: Smoking / Alcohol / Marijuana / Other

The information I have provided is true. I agree to treatment by Crystle Numan, Manual Therapist.

Signature: _____ Date: ____ / ____ / _____ (m/d/y)

Guardian signature (if under 18): _____