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