Client Intake Form

Standing Oak Therapy

Date _____ D.O.B. _____ Age _____

Name _____ email: _____

Address _____ City, ST Zip _____

Phone _____ Mobile _____ Work _____

Occupation _____ Employer _____

In case of emergency, please notify: Name _____ Phone _____

Current or Previous major illnesses _____

Current or Previous injuries or accidents _____

Please check if any of the following are relevant to your medical history:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Other _____
- ☐ Epilepsy/Seizures
- ☐ Flu/Cold
- ☐ Headaches
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Previous MVA/trauma
- ☐ Osteoporosis
- ☐ Scoliosis/Lordosis
- ☐ Skin Disorders
- ☐ Sinus Problems
- ☐ Varicose Veins
- ☐ Any infectious conditions _____

Females Only *- please mark if you are or are trying to get pregnant* ☐ _____ weeks

Are you currently under the care of a physician? ☐ No ☐ Yes *if yes,* _____
Name Phone

Are you currently taking any medications? ☐ No ☐ Yes *if yes, please list* _____

Purpose/Reason for today's visit _____

Are you allergic to any nuts or oils? ☐ No ☐ Yes _____

For injuries/pain:

Areas of any discomfort/pain _____

How long have you had this pain/injury? _____

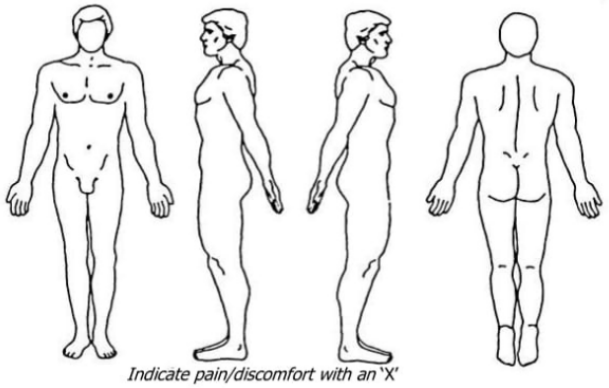
Have you sought out other therapies/treatments? ☐ No ☐ Yes

if yes, list _____

*** what do you think is causing injury/pain?** _____

Do you exercise regularly? ☐ No ☐ Yes

Type _____ *Frequency* _____



Indicate pain/discomfort with an 'X'

What is your goal for this session? _____

_____