Client Intake Form

Rev May-2020

Name:		DOB:	
Parents Name (if under 18:			
Referred By:			

What are your goals? (Prioritize if more than one)

☐	Early Development	☐	Anxiety	☐	Injuries
☐	Sensory, Self-Regulations	☐	Balance, Vertigo	☐	Post-surgical Function
☐	Academic, Reading, Focus	☐	Pain	☐	Staying Active
☐	Other:				

Details (for example: when did it start? how often? what else have you tried? etc.):

General Health:

☐	Yes	☐	No	Are you currently pregnant?
☐	Yes	☐	No	Are you currently treated for a neurological, autoimmune condition, or cancer?
☐	Yes	☐	No	Are you currently treated for a chronic pain condition such as fibromyalgia?
☐	Yes	☐	No	Have you had corrective eye surgery for lazy eye or crossed eye?
☐	Yes	☐	No	Have you had an active disc or spinal injury?
☐	Yes	☐	No	Are you experiencing issues related to a traumatic brain injury (TBI)?

Injuries (including auto accidents, falls, concussions, bike accidents, traumatic events, etc.):

Age	Event	What happened?

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Fractures, Surgeries (include cosmetic and dental surgeries):

Age	Fracture/Surgery	Cast? Immobilization? Complications?

Health History:

- **Cardiac:** Including Ablation, A-fib, Blood Pressure (high, low), Bypass, Congestive Heart Failure, Pacemaker, ICD, POTS, Stent
- **Digestive**: Including Appendix, Bladder, Diabetes, Gallbladder, Hernia, IBD, IBS, Kidney, Liver, Pancreas, Reflux, Ulcers
- **Respiratory**: Including Apnea, Asthma, Bronchitis, COPD, Pneumonia

Age	Procedure/Event	Describe

- **ENT/ Maxillofacial**: Including Dental implants Jaw, Nasal, Tonsils, Sinus
- **Cosmetic Procedures**: Including Breast Reduction/Enhancement, Facial Reconstruction, Abdominal Reconstruction, Liposuction/Cryo-Reduction
- **Skeletal Conditions:** Including Arthritis, Joint Replacement, Osteoporosis, Scoliosis

Age	Procedure/Event	Describe

- **Autoimmune Conditions**: Including Crohn's, Euhler-Danlos, Epstein-Barr, Fibromyalgia, Lyme, Rheumatoid Arthritis
- **Neurological Conditions**: Including Meningitis, Migraines, MS, Neuropathy, Parkinson's, Seizures, Cranial Shunts, Lumbar Punctures
- **Reproductive System**: Births, C-section, Cysts, Endometriosis, Hysterectomy, IVF or similar, Miscarriage, PCOS, Testes

Age	Procedure/Event	Describe

- **Cancer Treatment**: Biopsies, Chemo, Radiation, Surgery, Reconstruction, Picc lines, Port-a-caths

Age	Procedure/Event	Describe

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- **Auditory/Hearing**: Cochlear Implant, Ear Tubes, Hearing Aids, Auditory Processing
- **Sensory**: Tactile defensive, Seeking, Avoiding
- **Vision**: Near/Far sighted, Amblyopia, Strabismus/Crossed Eye, Tracking, Convergence/Divergence, Eso/Exotropia, Glaucoma, Macular Degeneration

Age	Procedure/Event	Describe

Mental Health Considerations:

	Anxiety		ASD		Depression		Self-harm
	ADD/ADHD		Bipolar		PTSD		Stress
	Addiction		Dementia		Schizophrenia		Trauma
	Other:						

Medications/Supplements Regularly Taken:

Name of Medication	Taken For

Professionals You May be working with (check all that are appropriate):

	Chiropractor
	Holistic Health
	Mental Health Professional
	Occupational Therapist
	Physical Therapist
	Speech Therapist
	Vision Therapist
	Other:

Anything else you'd like to let us know:

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Prenatal Period and Birth (if known, it is useful information):

☐	Normal	☐	Amniotic Fluid issues	☐	Twin- Top/ Bottom?	☐	Maternal Bed Rest
☐	Adopted	☐	Breech	☐	Umbilical cord issues	☐	Blood Pressure
☐	IVF	☐	IUGR	☐	Meconium	☐	Pre-term: ____ weeks
☐	Surrogate	☐	Placental Issues	☐	Jaundice	☐	NICU?
☐	Other:						

Birth Characteristics: (Describe what you know about your birth. Fast, long, C-section, Forceps Sunnyside up, etc.):

Early Medical Procedures and Hospitalizations (for example: IV's, Lumbar Puncture/Spinal Tap, etc.):

Age	Procedure/Event	Describe

Early Developmental Considerations (Check all that apply):

☐	Failure to Thrive	☐	Late Crawling	☐	Late talking	☐	Sleep Concerns
☐	Late Sitting	☐	Foot Braces	☐	Head Helmet	☐	Late Walking
☐	Corrective Shoes	☐	Other:				

Infancy Health (Birth-3 years – Check all that apply):

	Respiratory		**Digestive**		**Cardiac**		**Skeletal**		**Misc.**
☐	Apnea	☐	Colic	☐	Flap Closure	☐	Arms/Hands	☐	Dehydration
☐	Asthma	☐	Constipation	☐	Murmur	☐	Clavicle	☐	Fevers
☐	Breathing	☐	Diarrhea	☐	Valve Issues	☐	Cranial Fusion		
☐	Bronchiolitis	☐	Hernia			☐	Facial		
☐	Pneumonia	☐	Reflux			☐	Feet/legs		
☐	RSV					☐	Hip Dysplasia		
						☐	Spine		
						☐	Torticolis		
☐	Other:								

All of the above information is correct and complete to the best of my knowledge.

Name:		Date:	
Completed by (if parent/guardian):			