CLIENT INTAKE/HEALTH HISTORY

Name:____

Address:____

____

Phone Number :(H)____

(W)____

(C)____

Email Address:____

Date of Birth:____

Personsal Physician:

Name:____

Phone Number:___________________________________

Emergency Contact:

Name:____

Relationship:____________________________________

Email:_______________________________________

Phone Number:___________________________________

How did you hear about our studio?_____________________________________

(please complete back side of page as well)

Please list any and all injuries, past or present:____

Are you currently taking any medication and/or supplements? If yes, please list:

Do you have any medical conditions or illnesses? If yes, please list:

What does your daily activity consist of? (i.e. sitting at a computer, heavy lifting, caring for children …)

What are your goals in participating in our program(s)?

PLEASE NOTE: All information provided in this form is strictly confidential and will not be shared with any third party without your written consent. It is important that we screen for possible contraindications to the type of service(s) we offer. Your health and safety are our greatest concern.