EFFECT THERAPY

CLIENT INTAKE FORM

Confidential

The information collected on this form is used to help your therapist make an informed assessment and effective treatment plan. Your personal information is kept confidential.

Records are stored securely for seven (7) years after last treatment date.

Personal Information

Name	(last)	(first)	(initial)
Date of Birth	(month)	(day)	(year)
Address	(full address with postal code)		
Phone	(cell)	(home)	(work)
E-mail Address			
Occupation			
Doctor	(name)		(phone)
Chiropractor	(name)		(phone)
How did you hear about us?			
May we contact your doctor if necessary?	[ ] Yes		[ ] No

Medical Information:

Chief Complaint	
Other Complaints	
Type of Pain (Dull, Sharp, Pinch, etc.)	
Level of Pain	1 2 3 4 5 6 7 8 9 10 Mild Pain Scale Severe
Does it radiate? If yes, where?	
What relieves pain/condition?	
What aggravates pain/condition?	
Previous Injuries	
Any surgeries? If yes, please describe	

Please check all that apply:

	Allergies		Dizziness		Hernia		Constipation
	Arthritis		Epilepsy		High Blood Pressure		Stroke
	Cancer		Fainting		Low Blood Pressure		Ulcers
	Contact Lenses		Headaches		Painful Menstruation		Varicose Veins
	Diabetes		Heart Disease		Pregnancy		Other
	Digestive Disorders		Hemophilia		Pain or Stiffness		
	Pins, Plates, Prosthesis		Hardening of the Arteries		Lung/Respiratory Disorder		

Additional information to be recorded by therapist.

Lifestyle Information:

	Never	Occasionally	Regularly
Tobacco			
Alcohol			
Caffeine			
Vitamins			
Exercise			
Medications			
If taking medications, please list:	Medication:	Taking For:	

Effect Therapy Newsletter

- Yes, I would like to receive Effect Therapy's Monthly Newsletter! initial: _____

Declaration and Consent

- I declare that the information provided, and all statements made by me on this form are true and complete to the best of my knowledge.
- I understand that the information I have provided will be used to make assessments and create treatment plans.
- I understand that I have the right to refuse and end treatment if at any time I feel unsafe or uncomfortable.

Name_____ Signature_____ Date_____