Returning Client Intake

Client Name:_____ **Date:**_____

Was last treatment helpful? How did you feel? _____

_____

Changes to health or medication since last visit? _____

_____

Goals/Intentions for today _____

_____

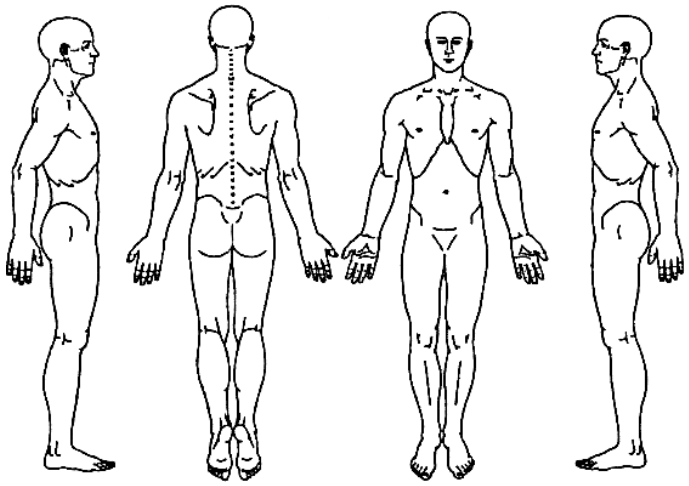
Symptoms you have ***Now*** and ***Recently***. Mark ALL that apply.

☐ Cold or flu	☐ Cough	☐ Anxiety	☐ Sprain, strain
☐ Fever	☐ Itching or Rash	☐ Dizziness	☐ Cramps/spasms
☐ Swollen glands	☐ Open sores/wounds	☐ Headache	☐ Swelling/Edema
☐ Sinus pain	☐ Allergic reaction	☐ Tremors	☐ Pain
☐ Any infection-anywhere	☐ Difficulty breathing	☐ Bruises, Hematoma	☐ Reduced sensation
	☐ Weakness	☐ Aches	☐ Other _____
☐ Chest pain	☐ Fatigue	☐ Numbness	_____

Explain and/or mark on body map _____

_____

Mark current symptoms: aches, pains, tension, numbness, tingling, stiffness, wounds, etc.



Pain level (0-10) _____

Function level (0-10) _____

Are you getting enough sleep? always usually sometimes rarely never

Perceived General Health: very healthy, average, ok, tolerable, other _____

I have been provided with an informed consent form. I have read it, had the chance to ask questions, and freely give consent for treatment.

Signature_____ **date**_____