Client intake form for Structural Integration.

This information is strictly confidential

PLEASE PRINT CLEARLY

Name ________________________________ Date: ______________

Address ________________________________ DOB_________________________

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Phone (h)____________ (w)_____________

Cell Phone ______________________________

Occupation ______________________________ Email ______________________________

Do you have any medical conditions or illnesses?

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Are you presently under the care of a medical physician/chiropractor/therapist? Y N

If yes, for what?

____

Do you have any chronic bodily discomfort?

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What do you hope to gain from your Treatments?

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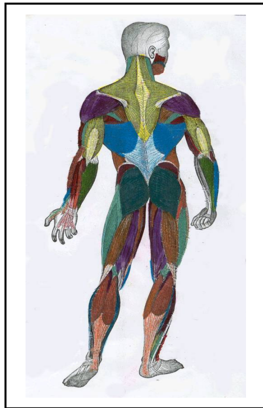
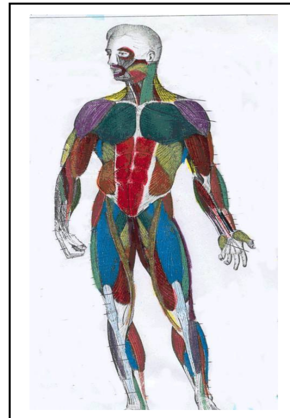
Please circle the areas that you have discomfort, injuries, accidents, and surgeries?





I certify that the above information is true and accurate to the best of my knowledge.

If I need to reschedule an appointment for any reason, I will give at least 24 hours

____ _______________________

Signature of Client Date