Melody Craven, L.M.T. – Client Intake Form

Date: _____

Last Name:_____First Name: _____

Street Address_____

City:_____State:_____Zip:_____

Home Phone:_____ Cell/Work Phone:_____Preferred contact #_____

Occupation:_____ Hobbies:_____

Date of Birth:_____Height: _____'_____"_Weight: _____lbs.

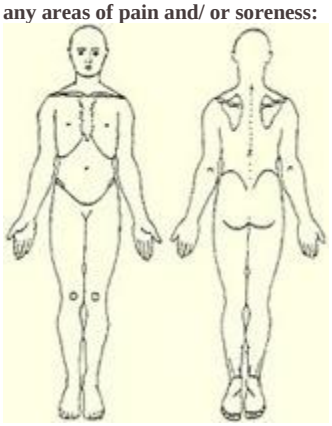
Referred by:_____

What are your goals for this treatment?_____

_____

What is your major complaint or condition you want to improve?_____

Please indicate by an (X) to the right any areas of pain and/ or soreness:



Are you under any medical/ therapeutic treatment? Yes_____ No_____

If yes, for what condition?_____

_____

Please list any medications (including aspirin) and nutritional supplements you are taking:_____

_____

Specify any known allergies:_____

Please list any other comments regarding your health and well-being:_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the therapist of any changes to my medical health and wellness.

Client signature:_____Date_____