



DORFMAN  
KINESIOLOGY

## Client Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_ : Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_

Activities regularly pursued: \_\_\_\_\_

Approximately how much time per day/week/month? \_\_\_\_\_

Stress reduction activities: \_\_\_\_\_

Approximately how much time per day/week/month? \_\_\_\_\_

### **Describe the condition for which you are seeking treatment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

What is your level of pain today? (scale of 1-10 ; 10 being severe): \_\_\_\_\_

Is this condition getting worse?

\_\_\_\_\_yes \_\_\_\_\_no \_\_\_\_\_constant \_\_\_\_\_comes & goes

Is this condition interfering with your \_\_\_\_\_work \_\_\_\_\_sleep \_\_\_\_\_daily routine

If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Have you had this or similar conditions in the past? Y / N

If so, please explain:

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What have you already done to treat this condition?

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Has prior treatment been helpful? Y / N

Are you currently under the care of a health care practitioner? Y / N

If so, please list name and location: \_\_\_\_\_

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Please list any medications, supplements or natural remedies/herbs you currently take:

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If you have had any surgeries, accidents, injuries, serious illnesses, or hospitalizations, please list them and the date(s) and treatment(s):

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List all allergies:

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**Health Conditions:**

Check all that apply to you:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Depression              | <input type="checkbox"/> Numbness/Tingling  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Open Cuts or Sores |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Digestion Problems      | <input type="checkbox"/> PMS                |
| <input type="checkbox"/> Blood Clots            | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Pregnant           |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> Rashes             |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Skin Disease       |
| <input type="checkbox"/> Chronic Pain           | <input type="checkbox"/> Menstrual Problems      | <input type="checkbox"/> Sleep Disorder     |
| <input type="checkbox"/> Communicable Disease   | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Other _____        |

I understand that yoga and bodywork should not be construed as a substitute for medical treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment. Because yoga and bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and will keep the practitioner informed of any changes prior to any future sessions.

I understand the benefits and risks of yoga and bodywork and give my consent for treatment. I will consult my practitioner with any questions or concerns immediately.

I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date