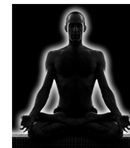

DORFMAN
KINESIOLOGY

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:
____
____

What have you already done to treat this condition**?**
____
____
____

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: ____
____

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

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

List all allergies:
____

Health Conditions:
Check all that apply to you:

Anxiety	Depression	Numbness/Tingling
Arthritis	Diabetes	Open Cuts or Sores
Asthma	Digestion Problems	PMS
Blood Clots	Fatigue	Pregnant
Breathing Difficulties	Heart Condition	Rashes
Bruise Easily	Headaches	Seizures
Cancer	High/Low Blood Pressure	Skin Disease
Chronic Pain	Menstrual Problems	Sleep Disorder
Communicable Disease	Migraines	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