

Intake Form

Name : _____ Date of birth: _____

Address : _____

Phone # : _____ (h) _____ (w)

E-mail address _____

Main health concern : _____

Blood type : _____ (O, B, A, AB) **Handedness (right or left?) :** _____

List supplements currently taking : _____

List any medications currently taking : _____

List any food sensitivities or cravings or other allergies:-

How much water do you drink per day? _____

Describe any sleeping problems: _____

Type of regular exercise? _____

Other therapies currently used on a regular basis: _____

NOTE: Please use the back for additional information.