ACORN SEMINARS
CLIENT INTAKE FORM

Client Name_____
Parent/Guardian Name_____
Address_____
Home/cell ph._____ **Bus. ph.**_____
Date of Birth_____ **Age**_____ **Sex M/F** **Marital Status S/M/D**
Occupation_____
In case of emergency, notify:_____ **ph. no.**_____

What is your major complaint?_____
_____
_____
Pain Scale: Best 0 1 2 3 4 5 6 7 8 9 10 Worst Constant___ Comes & Goes___
What are your minor complaints:_____
_____
_____
Pain Scale: Best 0 1 2 3 4 5 6 7 8 9 10 Worst Constant___ Comes & Goes___

Date of injury/onset of illness_____
What makes the complaint worse?_____
What makes the complaint better?_____
What other treatments have you rec'd for this complaint?_____
_____
Is this complaint interfering with your work? Y/N daily routine? Y/N sleep? Y/N
What is the quality of your sleep? _____ **How many hrs./night** _____

Has there been a medical diagnosis?_____
By whom?_____ **date**_____
X-rays? Y/N MRI? Y/N CATS? Y/N Urine Analysis? Y/N Bloodwork? Y/N

List all types and dates of:
injuries_____
surgeries_____
hospitalizations_____

List any and all healthcare providers:_____
_____

List all medications including OTC, herbs, vitamins and supplements:
_____
_____
List any allergies_____

Are you taking any of the following? laxatives___ aspirin___ blood thinners___ sleeping pills___ insulin___ sedatives___ vitamins___ minerals___ herbs___

Habits: heavy (H), moderate (M), light (L), none (N)
alcohol____ coffee____ tea____ soda____ tobacco____ recreational drugs____
How many glasses of water do you drink/day? _____
Exercise? Y/N How many days/hours week? _____ What kind? _____
What is daily stress level? Low 0 1 2 3 4 5 6 7 8 9 10 High

Please list any current (C) or past (P) issues that you have had relating to:
cardiovascular___ infections___ endocrine___ neurological___ urinary___ reproductive___ pulmonary___ skin___ digestive___ muscles/joints___ internal___ ears/eyes/throat___

Please list any family health history relating to:
cancer___ diabetes___ cardiovascular___ high blood pressure___ kidney problems___ high cholesterol___ headaches___ anemia___ arthritis___ autoimmune disorders___ obesity___ alcoholism___ drug abuse___ depression___ anxiety___ other_____

Additional comments_____
_____

Acorn Seminars Clinic Policies:

- **If you are unable to keep your appointment, kindly give us 24 hours notice, otherwise, a charge will be made for the time reserved.**
- **It is recommended that first time clients schedule 4-6 sessions sequentially (1x per week) for best results.**
- **Substitutions and alterations to scheduled appointments must have therapist approval beforehand.**
- **Clients who are consistently late for appointments may forfeit their rights to full sessions.**
- **All clients are required to read Acorn Seminars clinic page on website: www.acornseminars.com**
- **All clients are required to read, understand, and sign consent forms.**
- **Client's failure to comply with ASI policies may result in dismissal.**

Printed Name, Signature, Date _____