

Initial Intake Form

Name: _____

Date: _____

Address: _____

Brithdate: _____

_____ Zip: _____

Height: _____

Phone: _____

Weight: _____

cell: _____

Email: _____

Brief description of reason for appointment:

List major health concerns:

Are you being treated by a physician? NO

YES, for what?

Are you taking any medications?

supplements/herbs?