



Client Intake

Name _____ Birth date _____ Today's Date _____

Address _____

Phone _____ Email Address _____

Occupation _____ Referred By _____

Emergency Contact and Phone _____

Payment Authorization: Credit Card Visa/MC # _____ Expire _____

Payment authorization is only used for outstanding balances should client be absent from studio more than two weeks

Health History: If you answer yes to any answers below please describe answer on right column

Sprains, fractures, strains	Yes	No	
Chronic muscle or joint Issues	Yes	No	
Arthritis	Yes	No	
Pregnancy	Yes	No	
Surgery	Yes	No	
High Blood Pressure	Yes	No	
Heart Disease	Yes	No	
Cancer	Yes	No	
Other			
Medications	Yes	No	
Exercise	Yes	No	
Smoke	Yes	No	

If you are receiving care from any of the following please provide us with name and contact information.

- Physical Therapy
- Chiropractic
- Body Work
- Physician

Please state what you would like to achieve with your sessions at EPY Center: