



Client Intake

Date: _____

Name: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Text confirmation OK? _____

Address: _____

Gender: _____

Marital Status: _____

Occupation: _____

Height _____

Weight _____

How did you hear about Wolf Moon? _____

What is the primary goal that you would like us to help you with?

How long ago did this issue begin?

What are the secondary issues (if any) you would like us to help you with?

What kinds of treatments have you tried? _____

Have they helped your condition? _____

Are you currently receiving treatment for this condition? If so explain _____

Current or past illnesses: _____

Surgeries: _____

Significant Trauma (accidents, falls etc) _____

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Do you have or have you had any infectious diseases? _____

Do you have any allergies? _____

Is there any other information that would be important to know for your treatment? _____

Medications

Name	Reason for Taking	Dose	Date Started
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Current Quality of Life:

Current Emotional Health:

Stress Level of Occupation:

Have you had any unusual stresses lately? If so, explain

Your favorite time of year? _____ Least Favorite? _____

Hobbies and recreational habits:

Do you exercise regularly? _____ Describe: _____