Longevity
Brain & Body
Wellness, LLC

NEW CLIENT INTAKE FORM

DATE:

LAST NAME:	FIRST NAME:
ADDRESS:	APT OR PO BOX:
CITY:	STATE:
ZIP CODE:	DATE OF BIRTH:
PHONE: ( )	ALTERNATE PHONE : ( )
EMAIL:	

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:
PHONE: ( )	
RELATIONSHIP:	

PROBLEM/CONDITION

DESCRIPTION OF PROBLEM OR REASON FOR CONSULT:
REFERRED BY:
DATE OF ONSET:

PERTINENT MEDICAL HISTORY

CURRENT:
PAST:
SURGERY:

PHYSICIAN NAME:
PHYSICIAN PHONE:
PHYSICIAN FAX:
PHYSICIAN ADDRESS:

I AM INTERESTED IN (CHECK ALL THAT APPLY):

- Speech Therapy
- Physical Therapy
- Brain Health
- Wellness/Fitness
- Ergonomic Consultation
- Sports Performance/Injury Prevention
- Prenatal/Postpartum Wellness/Fitness