Intake form

Today's Date ____________________

Name ____________________ Date of Birth (M/D/Y) ____________________

Address ____________________ City ____________________

Postal Code ____________________ Phone ____________________

Email ____________________ Occupation ____________________

Primary Health Care Provider ____________________

Emergency Contact ____________________ Phone ____________________

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV Wellness Boutique Inc. specials and newsletter.

Other Health Care Providers

Name ____________________ Name ____________________

Profession ____________________ Profession ____________________

Phone ____________________ Phone ____________________

Health information

List your health concerns (physical, emotional or psychological) in order of importance to you, and the date your symptoms began:

1. ____________________ Date ____________________

2. ____________________ Date ____________________

What do you believe is causing your most important health concern?

____

____