CARLY S. VERNON, LMT
339.222.4938
LEXINGTON AND WINCHESTER

Client Intake Form

Date

Name	
Date of Birth	
Cell Phone	*Text ok? Y N*
Email	
Street	
City/State/Zip	
Emergency Contact Number	

Referred By

Reason for Today's visit

Other treatment modalities you've used or are currently using for this or any condition
(circle)
DC DO PT MD
Massage Acupuncture
Other (specify):

Name and Number of Specialist (if currently receiving tx)

Smoke Y N **Nut Allergy** Y N

Body Placement/Movement

Occupation	
Hrs/day @Computer/Desk	
Hrs/day in Automobile	

(circle) Standard Automatic

Exercise	
Frequency	
Hobbies/Activities (non exercise)	
Hrs/week	

Life Stress Level

0|----------5----------|10

Sleep

Hrs Sleep/Night	Do you wake feeling rested: Y N	Positions (circle) Side Back Stomach
Age of Mattress	Pillow Y N	Quality of Sleep 0|----------5----------|10

Please complete side 2 →

Date of Diagnosis / Presentation	Conditions/Surgeries	Suspected	Diagnosed by medical professional

- ☐ Allergies *Type*:
- ☐ Anxiety
- ☐ Arthritis *Please note location on chart*
- ☐ Bladder Control Issues
- ☐ Bleeding Disorder
- ☐ Cancer

Type and Course of Treatment

- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ DVT/Blood Clot
- ☐ *Please note location on chart*
- ☐ Fibromyalgia
- ☐ Fatigue
- ☐ Fungal Infection
- ☐ *Please note location on chart*
- ☐ Glasses/Contacts
- ☐ Headaches/Migraines (circle)
- ☐ Heart Attack *Date*
- ☐ Hypertension
- ☐ IBS
- ☐ Insomnia
- ☐ Lymphedema
- ☐ *Please note location on chart*
- ☐ Medicated patch *Type*:
- ☐ MS
- ☐ Nerve Pain/Numbness (see chart)
- ☐ Paralysis *Location*
- ☐ Pelvic Floor Dysfunction
- ☐ Plantar Fasciitis
- ☐ Prosthetic
- ☐ Rash
- ☐ *Please note location on chart*
- ☐ Shingles
- ☐ Sinus Condition (circle)

current chronic

- ☐ Sprains/Strains
- ☐ TMJ Dysfunction
- ☐ Tinnitus
- ☐ Whiplash
- ☐ Other:_____
- ☐ Other: _____

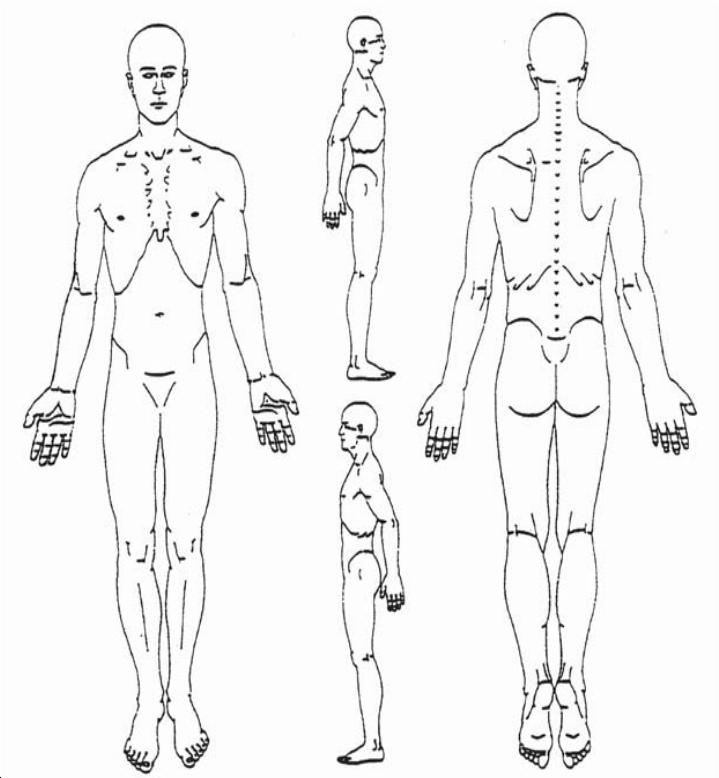
The information listed on this form is for proper assessment and safe treatment only. This information will be held in the strictest confidence and will be shared with another practitioner only with the written consent of the patient. By signing below, patient acknowledges that the above listed information is complete and accurate. The patient also acknowledges that the omission of information may alter the efficacy of treatment.

Patient Name (Please Print) Patient Signature Date

Please label the body below by drawing a line to the location of area of concern and label with supplied letter or number.

Use remaining letters/numbers as needed.

Please feel free to illustrate any radiation/areas of sensation



Sensations/Other	
1	Numbness/Tingling
2	Pain (sharp)
3	Pain (dull/throbbing)
4	Pain with movement
5	Muscle Tension (“knots,” etc)
6	
7	
8	
9	
10	

Conditions/Diagnoses	
A	Surgery
B	Arthritis Type:
C	Fracture (date)
D	Fibromyalgia tender point
E	Spinal Issues (circle) herniation, stenosis, impingement, scoliosis Vertebra #’s
F	Sciatica
G	Muscle / Tendon tear Approx Date:
H	
I	
J	