New Client Intake Form
Amma Apprenticeship Student Clinic

Name: ____ Date: ______________

Address: ____

City: ________________________________ State: ______________ Zip: ____________

Email: ____

Home Phone: _________________________ Work/Cell Phone: ______________________

Occupation: ___________________________ Referred by: _________________________

Emergency Contact: _____________________________ Relationship: __________________

What are your primary health concerns?

____

____

____

Are there any medical conditions or allergies that we need to know about?

____

____

Please list any medications or supplements you are currently taking:

____

____

FAMILY/PERSONAL HISTORY

Circle illnesses which have occurred in any of your blood relatives:

Diabetes Heart disease Anxiety Kidney disease
Cancer Stroke Depression Alcoholism
High blood pressure Obesity Allergies Hashimoto's/Hypothyroidism
Other: ____

Circle illnesses or conditions you have currently or have had in the past:

Diabetes Anxiety Alcoholism Jaundice
Cancer Depression Hashimoto's Hepatitis
High blood pressure Allergies Hypothyroidism Glaucoma
Heart Disease Asthma Hyperthyroidism Palpitations
Stroke Obesity Kidney disease HIV Antibiotic use
Other: ____

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Please list any serious injuries, surgeries or hospitalizations and corresponding dates:

____

____

____

What is your average level of energy on a scale from 0 to 10, with 0 being no energy and 10 being lots of energy? _____

What is your average level of stress on a scale from 0 to 10, with 0 being no stress and 10 being lots of stress? _____

Are you physically active? What types of exercise do you do and how often?

____

What are your goals or expected outcomes for receiving treatment?

____

Are you currently receiving care from: Chiropractor ____ Acupuncturist ____ Medical ____
Dentist ____ Physical Therapist ____ Massage Therapist ____Nutritionist ____

Women only
Are you currently pregnant: yes / no If so, how many months: ______________________________

The beginning date of your last menstrual cycle: ______________________________________

Reproductive issues: _________________Irregular Mensturation: ________________________

Do you use:
- Alcohol? yes / no
- Tobacco? yes / no
- Coffee? yes / no
- Marijuana? yes/no
- Carbonated drinks? yes / no

How many glasses of water do you drink a day? __________

COMMENTS (anything else you would like to tell us):

____

____

____

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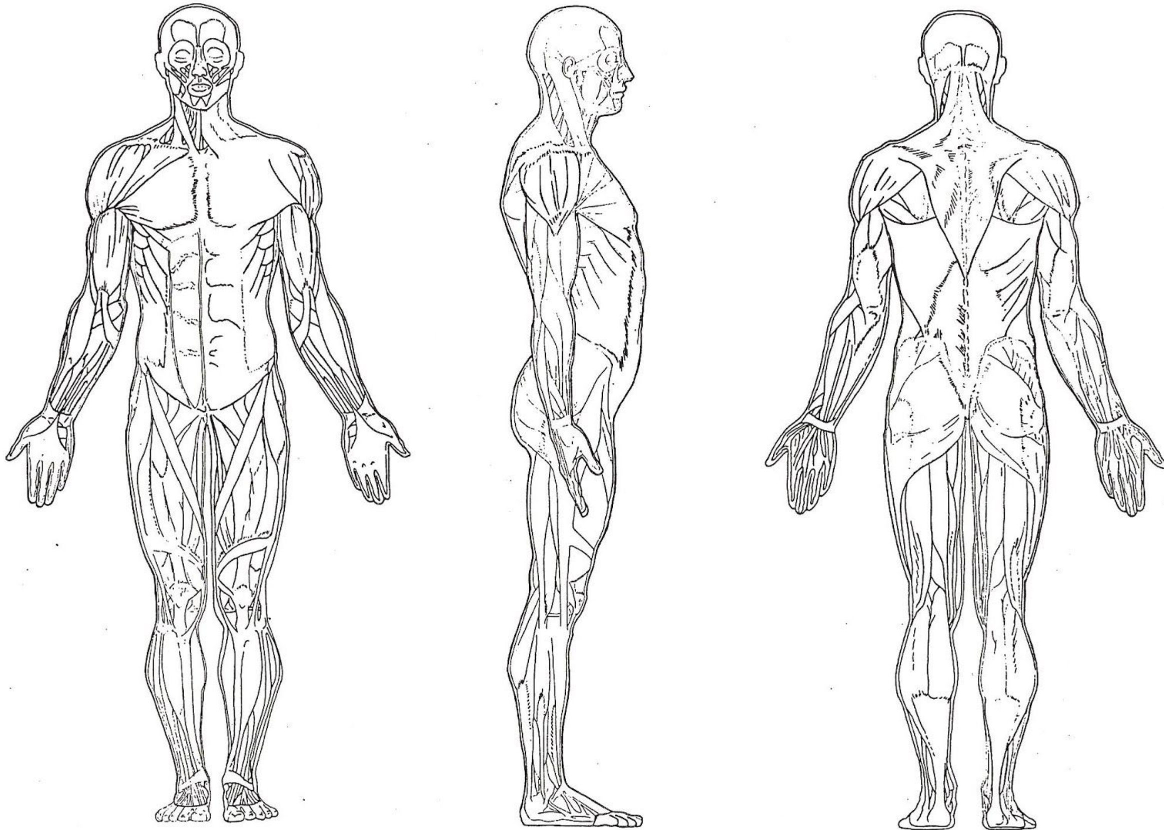
PLEASE MARK YOUR AREAS OF PAIN



The Amma Apprenticeship is run by April Crowell Dipl. ABT (NCCAOM), AOBTA CI & CP. By initialling the following you recognize that the Amma treatment you are recieving is given by a student, under supervision, in the process of finishing their required hours and not by a certified practitioner.

All of your information is confidential and will not be discussed without your consent. The Amma Apprenticeship program run by April Crowell, Dipl. ABT and adhears to Pulse's posted HIPPA policies.

By signing below you acknowledge that you have been given the opportunity to review Pulse's posted HIPPA policy and that you understand that the Amma apprentices are not medical doctors and that the therapy and suggestions made are in no way meant to replace conventional medicine or treatment when and if necessary.

Signature: ____ Date: _____________________________

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