# Andréa Silk, MS. L.Ac.

*Integrative Wellness Specialist*

## Client Intake Form

### Personal Information

Full Name: ______________________________ DOB: ______________________

Address: ________________________________________________________

City: ______________________________ State: __________ Zip: __________

Phone #: __________________________ Email: __________________________

Occupation: _______________________

### Medical History

Health Conditions: ______________________________________________

Medications Being Taken: ________________________________________

Please indicate any of the following conditions that you currently have:

| | | |
|---|---|---|
| ☐ headaches | ☐ allergies | ☐ arthritis, tendonitis |
| ☐ cancer | ☐ TMJ | ☐ abnormal skin conditions |
| ☐ heart/circulation problems | ☐ joint surgery | ☐ high/low blood pressure |
| ☐ major accident | ☐ varicose veins | ☐ blood clots |
| ☐ neck/back injuries | ☐ diabetes | ☐ fibromyalgia |
| ☐ numbness | ☐ sprains, strains | ☐ recent injuries |

Explain any conditions you have marked above:

________________________________________________________________

________________________________________________________________

________________________________________________________________

Client Signature: ______________________________ Date: ________________