9 CORNERS
CENTER for BALANCED LIVING

Short Intake Form Part 1

Today's Date:

Your Name:

What is the primary reason(s) for your visit?

Are you currently taking any medications? Please list:

Are you currently taking any vitamins, herbs, nutritional supplements? Please list:

How often do you have a cold or flu during a year?
Please circle: Never 1-2 times 3-4 times 5 or more

How many hours of uninterrupted sleep do you get per night/
Please circle: 10 or more 8-10 hours 6-8 hours less than 6always interrupted

How much exercise do you perform each week?
Please circle: Never 1-2 times 3-4 times 5 or more

When you feel your best what activities, circumstances, emotions, etc…do you attribute it to?

In the past what therapies/programs, have you found to be successful for you in achieving your health goals?

Have you experienced previous Injuries?

Hospitalization/Surgery Yes No
Accidents/Falls/Auto Yes No
Accidents on the job Yes No
Family History of Back Problems Yes No

Please indicate the number between 0-10 that best describes your pain. A zero would indicate "no pain" and a ten (10) would indicate "extreme pain". Your Pain Number:

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