InnerWorks Client Intake Form

807 N Waco, Suite 12, Wichita, KS 67203
316.946.0990

Today's Date______________________
Name______________________________________M_______F_______ Birth Date________________________
Phone: Home________________Work___________________Cell________________
Address_________________________________City___________________________State_____Zip____________
Parent or Guardian (if minor)__________________________Phone______________________________________
Emergency Contact_________________________________Phone______________________________________
Family Physician___________________________________ Referred by__________________________________
Occupation:____
How did you hear about InnerWorks:____
Reason(s) for this visit____
____
Medicines taken in the last two months (include vitamins, prescription and/or non-prescription drugs, herbs, supplements)____
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Are you pregnant?____________________ Which trimester?____

Do you have a history of the following? (check all that apply)

- ☐ accident/trauma
- ☐ addiction
- ☐ abdominal pain
- ☐ allergies
- ☐ arthritis, bursitis, gout
- ☐ attention/concentration difficulties
- ☐ bowel/digestion/ appetite/diet issues
- ☐ broken bones
- ☐ cancer
- ☐ carpal tunnel syndrome
- ☐ chills/fever/sweat
- ☐ colitis
- ☐ decreased range of motion
- ☐ diabetes
- ☐ emotional concerns
- ☐ fibromyalgia
- ☐ headaches
- ☐ heart attack
- ☐ high blood pressure
- ☐ HIV/AIDS
- ☐ infertility
- ☐ joint aches
- ☐ low back pain
- ☐ low / high energy level
- ☐ mastectomy
- ☐ lumpectomy
- ☐ lymph edema/ other swelling
- ☐ menstrual difficulties
- ☐ mid-back pain
- ☐ neck pain
- ☐ nervous tension
- ☐ PMS
- ☐ sciatica
- ☐ scoliosis
- ☐ seizures
- ☐ shoulder pain
- ☐ spiritual issues
- ☐ sprains
- ☐ stroke
- ☐ surgery
- ☐ tinnitus (ringing in ears)
- ☐ thyroid disorder
- ☐ TMJ issues
- ☐ upper back pain
- ☐ varicose veins
- ☐ vision problems
- ☐ vertigo/dizziness
- ☐ urination problems
- ☐ whiplash
- ☐ weight/eating issues
- ☐ other______________

If you answered yes to any of the above conditions, please specify:______________________________
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Family History: (Cancer, High Blood Pressure, Diabetes, Stroke, Osteoporosis, Heart Disease, Other) ____
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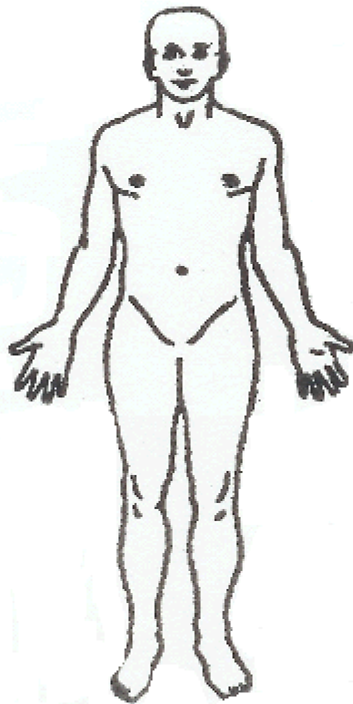
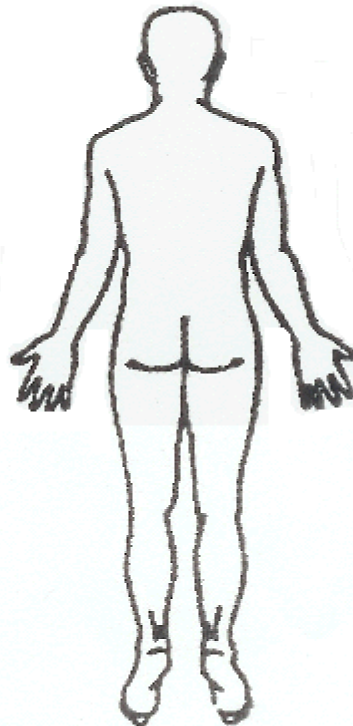
Please mark areas of pain with an "X" .





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Client Signature ____

IN ORDER TO BEST SERVE ALL OF OUR CLIENTS, THE COURTESY OF 24-HOURS NOTICE IS REQUESTED WHEN CANCELLING APPOINTMENTS. We would ask you to honor the time and schedule of the practitioner you were scheduled to see by paying for any appointments missed without this 24 hour notice. Thank you!

I understand that the staff at InnerWorks LLC does not diagnose illness, disease or any other physical or mental disorder as a medical doctor. As such, the InnerWorks LLC staff does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulation. It has been made clear to me that services offered at InnerWorks LLC is not a substitute for medical treatment and that it is recommended that I see a physician for any physical ailment that I may have.

I have stated all my known medical conditions and take it upon myself to keep InnerWorks LLC updated on my physical health.

Signature________________________________ Date ______________

Cancellation Policy

In order to best serve all our clients, the courtesy of 24 hours notice is requested when canceling an appointment.

We would ask you to honor the time and schedule of the practitioner you were scheduled to see you by paying for any appointments missed without this 24 hour notice.
Thank you!!