InnerWorks Client Intake Form

815 N. Waco, Suite 36, Wichita, KS 67203
316.946.0990

Today's Date_____

Name_____ M___ F___ Birth Date_____

Phone: Work_____ Cell_____ Home_____

Address_____City_____State_____Zip_____

Email: _____ Cellphone Co. (if you want text reminders)_____

Please tell us how you would like your appointment confirmations: Phone:___ Text:___ Email:___

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
- ☐ sleep
- ☐ 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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_____

_____

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_____

Family History: (Cancer, High Blood Pressure, Diabetes, Stroke, Osteoporosis, Heart Disease, Other) _____

_____

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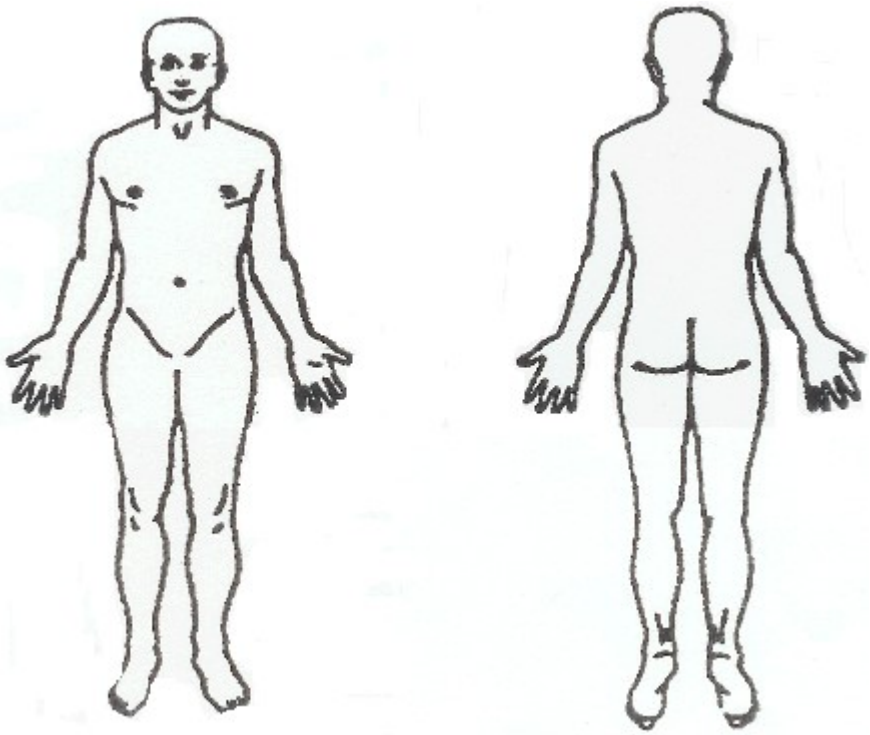
Please mark areas of pain with an "X", and numbness/tingling with a "*".



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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!