Mind Core
RETURN TO CENTER

New Client Intake

Today's Date_____

Name:_____ Age:_____ Sex: M F
DOB:____/___/____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____Work Phone:_____
Cell Phone:_____

Contact preference: Home ☐ Work ☐ Cell/Text Message ☐

Voicemail ☐Yes ☐No
May we confirm appointments by text message? ☐Yes ☐No

Email address:_____Receive e-Health info? ☐ Yes ☐No

Occupation:_____

If retired, former occupation/employer: _____

Pregnancies and births? _____. How many?_____

Have you ever been told you had a diastasis from pregnancy?_____

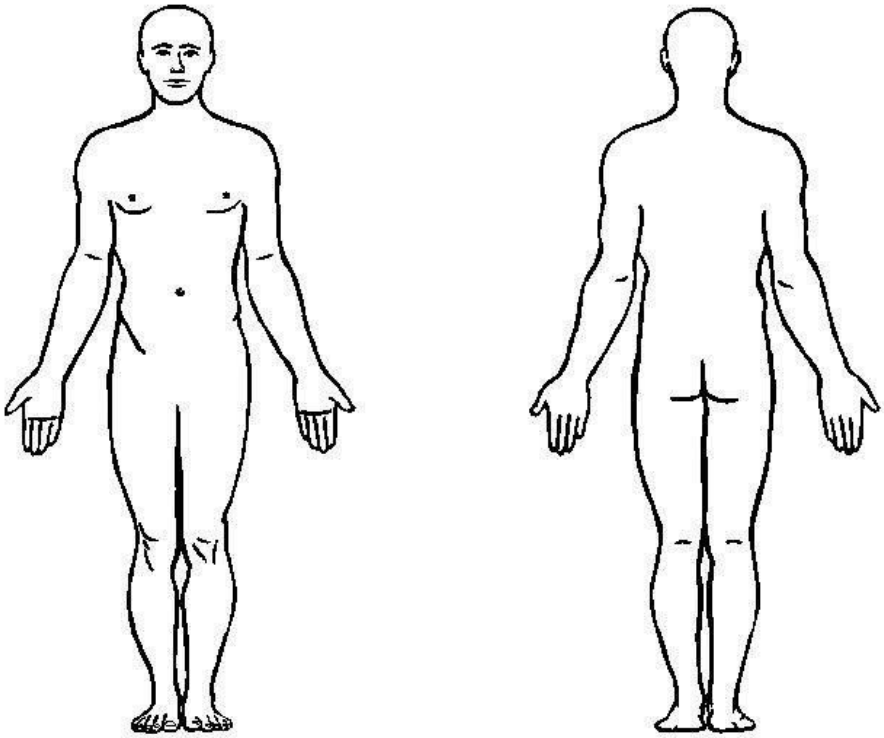
How did you hear about us?_____

PRESENT COMPLAINTS

1. Main issue:_____
   _____
   _____
   _____
   _____

2. History of injury(s) or surgeries
   _____
   _____
   _____
   _____
   _____
   _____

Please use this diagram to circle all injuries and surgeries including date of occurrence



Patient's Signature: _____