



# CLIENT INTAKE FORM

DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

FULL NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**Do NOT use PEMF if you have an implanted electronic device including but not limited to a pacemaker, defibrillator, cochlear hearing device, spinal stimulator, glucose monitor, or insulin pump, if you are pregnant or believe you may be pregnant, if you are actively bleeding or hemorrhaging, if you are the recipient of an organ transplant, or if you have injuries or concern of injuries that have not been evaluated by a licensed health care provider.**

Initials: \_\_\_\_\_

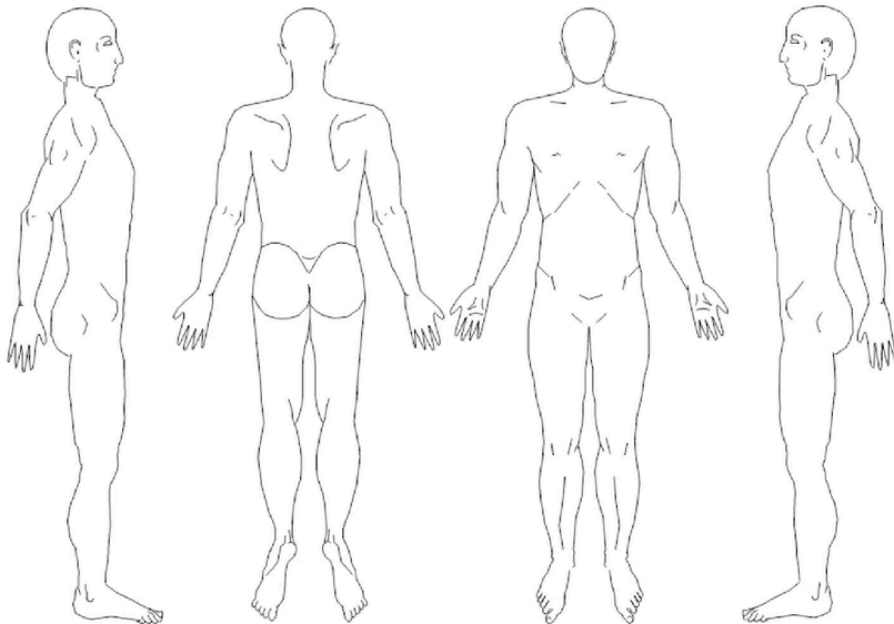
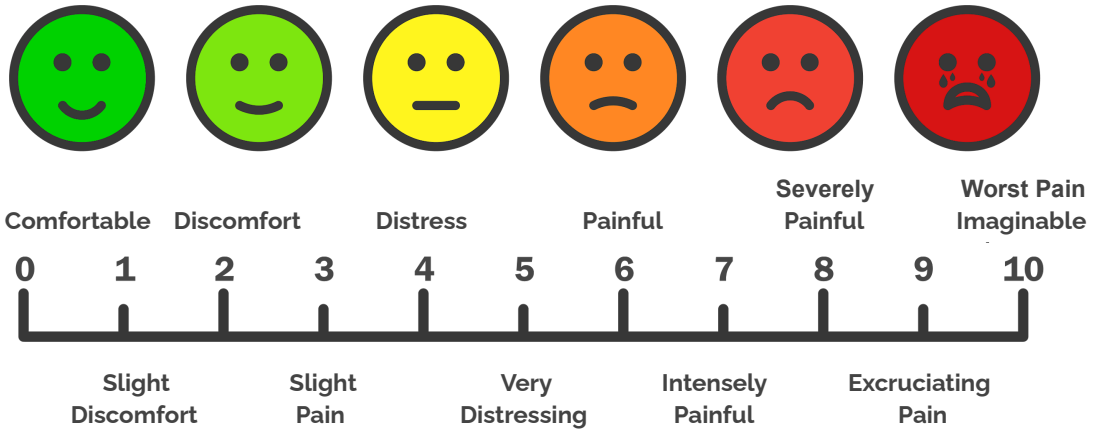
### Please check the box next to any medications you are currently taking.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Lisinopril<br>PRINIVIL   ZESTRIL  <br>QBRELIS                 | <input type="checkbox"/> Gabapentin<br>HORIZANT   NEURONTIN  <br>GRALISE  | <input type="checkbox"/> Acetaminophen<br>TYLENOL   OFIRMEV  <br>MAPAP   FEVERALL | <input type="checkbox"/> Amrix /<br>Flexeril  |
| <input type="checkbox"/> Lipitor   | <input type="checkbox"/> Hydrochlorothiazide<br>MICROZIDE   ESIDRIX  <br>HYDRODIURIL   ORETIC  <br>ZIDE           | <input type="checkbox"/> Celexa   | <input type="checkbox"/> Prinzide /<br>Zestoretic   |
| <input type="checkbox"/> Levothyroxine<br>LEVO-T   SYNTHROID  <br>EUTHYROX   LEVOXYL   | <input type="checkbox"/> Hydrocodone  | <input type="checkbox"/> Amphetamine<br>ADDERALL  <br>BIPHETAMINE  <br>MYDAYIS    | <input type="checkbox"/> Glucotrol  |
| <input type="checkbox"/> Metaformin<br>GLUCOPHAGE  <br>FORTAMET  <br>GLUMETZA   RIOMET | <input type="checkbox"/> Zoloft   | <input type="checkbox"/> Coreg  | <input type="checkbox"/> Cymbalta   |
| <input type="checkbox"/> Amlodipine<br>NORVASC   KATZERIA  <br>AMVAZ                   | <input type="checkbox"/> Pravachol  | <input type="checkbox"/> Trazodone<br>DESYREL   OLEPTRO  <br>TRIALODINE           | <input type="checkbox"/> Methylpheni<br>date<br>RITALIN  <br>METHYLIN  <br>DAYTRANA  <br>METADATE |
| <input type="checkbox"/> Metoprolol<br>LOPRESSOR   TOPROL                              | <input type="checkbox"/> Singulair  | <input type="checkbox"/> Fluoxetine<br>PROZAC   SARAFEM  <br>RAPIFLUX   SELFEMRA  | <input type="checkbox"/> Zantac /<br>Tritec   |
| <input type="checkbox"/> Prilosec  | <input type="checkbox"/> Lasix  | <input type="checkbox"/> Lexapro  | <input type="checkbox"/> Effexor  |
| <input type="checkbox"/> Fiolipid / Zocor  | <input type="checkbox"/> Amoxicillin<br>AMOXIL   MOXTAG  <br>LAROTID   DISPERMOX  <br>POLYMOX   TRIMOX  <br>WYMOX | <input type="checkbox"/> Insulin  | <input type="checkbox"/> Zolpidem<br>AMBIEN   EDIUAR<br>  INTERMEZZO  <br>ZOLPIMIST               |
| <input type="checkbox"/> Cozaar  | <input type="checkbox"/> Protonix   | <input type="checkbox"/> Klonopin   | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Albuterol<br>PROAIR   ACCUNEB  <br>PROVENTIL  <br>VENTOLIN    | <input type="checkbox"/> Tramadol<br>ULTRAM   CONZIP   RYBIX  <br>RYZOLT  | <input type="checkbox"/> Flomax   | _____   |
| <input type="checkbox"/> Fluticasone<br>FLONASE   XHANCE                               | <input type="checkbox"/> Xanax / Niravam  | <input type="checkbox"/> Tenormin   | _____   |
|  | <input type="checkbox"/> Prednisone   | <input type="checkbox"/> Potassium  | _____   |
|  | <input type="checkbox"/> Bupropion<br>WELLBUTRIN   FORFIVO  <br>APLENZIN   ZYBAN                                  | <input type="checkbox"/> Mobic  | _____   |
|  | <input type="checkbox"/> Ibuprofen<br>ADVIL   MIDOL   MOTRIN  | <input type="checkbox"/> Crestor / Ezallor  | _____   |
|  |   | <input type="checkbox"/> Plavix   | _____   |
|  |   | <input type="checkbox"/> Propranolol  | _____   |
|  |   | <input type="checkbox"/> Aspirin  | _____   |



# CLIENT INTAKE FORM

Use the below Rating Scale to describe your level of comfort.



**Circle any areas of your body where you are experiencing pain, sensitivity, inflammation, or have had a recent injury.**



# CLIENT INTAKE FORM

**Brief History of surgeries, illnesses, or medical issues:**

---

---

---

---

**Daily Activities (work, exercise, wellness regimen):**

---

---

---

---

**Print Name:** \_\_\_\_\_

**Sign Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PULSE PROFESSIONAL:**

**Print Name:** \_\_\_\_\_

**Sign Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_