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Client Intake Form

Date _____

PERSONAL

Name

Date of Birth

Occupation

CONTACT

E-mail

Phone | Day

Phone | Evening

Phone | Mobile

Address

EMERGENCY CONTACT

Name

Relationship

Phone

REFERRAL SOURCE

How did you hear about me?

HEALTH HISTORY

List all injuries | surgeries | accidents (include dates)

HEALTH HISTORY CONT'D

What is your primary concern/complaint?

What was it caused by?

What treatments have you received for it?

What helps the most?

What helps the least?

What do you do for physical exercise?

What do you do to relieve stress?

What do you want to get out of your session(s)?

Client Intake Form

Mark all areas of discomfort:

