EDUCATING
PROTECTING
HEALING

MIGHTY OAKS THERAPIES:
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CLIENT INTAKE (18+)

1. PERSONAL INFO

Name: _____ Date of Birth: _____

Gender: ☐ Male ■ Female Occupation: _____

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

Phone Number: _____ Email: _____

2. RELEASE OF INFORMATION

Primary Care Physician: _____

I would be willing to share with my practitioner the following:

- ☐ Most recent doctor's exam
- ☐ Environmental allergy testing
- ☐ Hair/mineral/tissue analyses
- ☐ Results of food allergy testing
- ☐ Homeoprophylaxis/vaccination records
- ☐ Epigenetic or genetic testing results
- ☐ Other: _____

Please return this completed form, along with any other essential documents, to stacyc@mightyoakstherapies.com.. Also, upload and attach any of the above-listed documents you are willing to share as well.

_____ _____

Signature Date