



## CONFIDENTIAL CLIENT INTAKE FORM

Name: \_\_\_\_\_ Date of Initial Visit \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Marital status \_\_\_\_\_ Referred by \_\_\_\_\_

Have you had massage/bodywork before? \_\_\_\_\_ What type? \_\_\_\_\_

### REASON FOR VISIT

What is your primary concern? \_\_\_\_\_

What are other areas of concern? \_\_\_\_\_

When did your first notice it? \_\_\_\_\_

Describe any stressors occurring at the time: \_\_\_\_\_

What activities provide relief? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_ Interfere with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Recreation? \_\_\_\_\_

Describe your exercise routine (type, frequency) \_\_\_\_\_

### FAMILY HISTORY

Parents living/ages? \_\_\_\_\_ Number/ages of siblings \_\_\_\_\_

Family History of Heart Disease? \_\_\_\_\_ Cancer? \_\_\_\_\_ Diabetes? \_\_\_\_\_

Family History of Abuse? \_\_\_\_\_ *Circle if applicable* : Physical Emotional Sexual Spiritual

Family History of Substance Abuse? \_\_\_\_\_ Suicide \_\_\_\_\_ Other Trauma \_\_\_\_\_

### DIGESTION & ELIMINATION

Typical Dietary Choices \_\_\_\_\_

Water Intake(glasses/day) \_\_\_\_\_ Caffeine \_\_\_\_\_

Are you subject to binge eating? \_\_\_\_\_ What foods? \_\_\_\_\_

Do you experience bloating/gas/burps after eating? \_\_\_\_\_ What foods trigger this? \_\_\_\_\_

How often are your bowel movements? \_\_\_\_\_ Do your stools: sink? \_\_\_\_\_ float? \_\_\_\_\_

Constipation? \_\_\_\_\_ Blood in stool? \_\_\_\_\_ Mucus in stool? \_\_\_\_\_ Pain when stooling? \_\_\_\_\_

**EMOTIONAL & SPIRITUAL**

What is your opinion of yourself? \_\_\_\_\_

If possible, please describe the most negative emotion you experience \_\_\_\_\_

When do you most often feel this emotion? \_\_\_\_\_

Do you pray or have a spiritual practice? \_\_\_\_\_

What are your hobbies or activities that provide you with a sense of pleasure and accomplishment?  
\_\_\_\_\_

What changes would you like to achieve in 6 months? \_\_\_\_\_  
One Year \_\_\_\_\_

**MEDICAL HISTORY**

Are you currently under the care of another health care provider(s)? \_\_\_\_\_ Reason (s) \_\_\_\_\_

Name(s) of Practitioner \_\_\_\_\_ Address: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies? Specify allergen and reaction: \_\_\_\_\_

Supplements/Remedies \_\_\_\_\_

Do you use Tobacco? \_\_\_\_\_ Quantity \_\_\_\_\_/ppd Alcohol? \_\_\_\_\_ Quantity \_\_\_\_\_ ounces/ day

Marijuana? \_\_\_\_\_ Quantity \_\_\_\_\_ Other: \_\_\_\_\_ Have you been under treatment for substance use?

If so, describe: \_\_\_\_\_

Surgical History (year and type) \_\_\_\_\_

Recent Procedures: \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Accidents or Traumas \_\_\_\_\_

Falls/Injuries to Sacrum/head/tailbone (describe) \_\_\_\_\_

Birth Trauma if known \_\_\_\_\_

Circle any of the following that are currently applicable to you  
Underline any of the following you have experienced in the Past

Headaches (migraine, tension, cluster)    Ringing in Ears    Pins and needles in arms, legs, hands or feet

Asthma    Cold Hands or Feet    Swollen ankles    Sinus Conditions    Seizures

Loss of Smell or Taste    Skin Disorders: *Acne, Fungus, Psoriasis* Other: \_\_\_\_\_

Sciatica    Painful Joints    Swollen Joints    Spinal Problems    Anxiety    Fatigue

Trouble Sleeping    Fainting Spells    Loss of Memory    Depression

Muscular Tightness: (location) \_\_\_\_\_    Varicose Veins (location) \_\_\_\_\_

Herniated or Bulging disc: (location) \_\_\_\_\_    High or Low Blood Pressure

Contact lenses    Dentures    Artificial /Missing limbs    Frequent Colds/ Upper Respiratory conditions

**REPRODUCTIVE HEALTH HISTORY**

Age of Menarche \_\_\_\_\_ What was this like for you? \_\_\_\_\_

How many Pregnancie(s) have you had? \_\_\_\_\_ Number of Deliverie(s) \_\_\_\_\_ Dates \_\_\_\_\_

Termination(s)? \_\_\_\_\_ When? \_\_\_\_\_

Miscarriage(s)? \_\_\_\_\_ When? \_\_\_\_\_

Complications? \_\_\_\_\_

What was your experience of: *Pregnancy* \_\_\_\_\_

*Labor* \_\_\_\_\_

*Delivery* \_\_\_\_\_

*Post Partum* \_\_\_\_\_

Maternal Family History of (*please circle*)    Infertility    Fibroids    Endometriosis

Cancer (type) \_\_\_\_\_    Menstrual Problems    Menopause    PMS

Method of Contraception: (*circle*) pills    patch    diaphragm    injection    condoms    IUD    abstinence    rhythm method

Other: \_\_\_\_\_

Length of time on synthetic contraception (Pill, Patch or Injection): \_\_\_\_\_

Last Pap smear \_\_\_\_\_ Results ( if known) \_\_\_\_\_

Date of Last Menstrual period \_\_\_\_\_ Length of Menses \_\_\_\_\_

Episodes of Amenorrhea? \_\_\_\_\_ When? \_\_\_\_\_ For how long? \_\_\_\_\_

Please circle symptoms as appropriate:

- |                                                   |                                      |
|---------------------------------------------------|--------------------------------------|
| Painful periods                                   | Irregular (late or early)            |
| Dark Thick Blood at Beginning or End of Cycle     | Dizziness with period                |
| Headache or Migraine with period                  | Excessive Bleeding (> one pad/hour)  |
| PMS/Depression with or before period              | Failure to Ovulate                   |
| Painful Ovulation                                 | Bloating/water retention with period |
| Heaviness or pressure in lower pelvis with period |                                      |

Other Symptoms (Circle and Describe as indicated)

- |                                             |                                                    |
|---------------------------------------------|----------------------------------------------------|
| Varicose veins of leg                       | Tired weak legs                                    |
| Numb legs and feet when standing still      | Sore heels when walking                            |
| Low back ache                               | Painful intercourse                                |
| Constipation                                | Endometriosis                                      |
| Endometritis                                | Uterine Polyps                                     |
| Fibroids (size and location if known) _____ |                                                    |
| Uterine infections                          | Frequent urination                                 |
| Bladder infections                          | Vaginal discharge (describe)                       |
| Vaginitis                                   | Vaginal Yeast infections                           |
| Chronic miscarriages                        | Premature deliveries                               |
| Weak newborn infants                        | Difficult pregnancy                                |
| Incompetent cervix                          | Spotting with pregnancy                            |
| Pelvic Inflammation                         | Sexually Transmitted Disease (date and type) _____ |
| Dry vagina (without menopause)              | Difficult menopause                                |
| Cancer                                      | Cysts (ovarian / breast)                           |

Are you under treatment for Infertility? \_\_\_\_\_ Describe current treatment to date : \_\_\_\_\_

Gynecological Provider: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Rate your interest in Sex: High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_ None \_\_\_\_\_

Do you have or have you had difficulty experiencing orgasms? \_\_\_\_\_

Have you experienced a history of rape? \_\_\_\_\_ trauma? \_\_\_\_\_ incest? \_\_ If so, when? \_\_\_\_\_

Did you undergo counseling for this? \_\_\_\_\_

MENOPAUSE (Circle the symptoms that apply to you)

- |             |              |                               |                            |
|-------------|--------------|-------------------------------|----------------------------|
| Hot flashes | Insomnia     | Fatigue                       | Memory Loss                |
| Mood swings | Irritability | Vaginal discharge (describe): |                            |
| Dry Vagina  | Fatigue      | Depression                    | Spotting (menses)          |
| Flooding    | Clotting     | Irregular menses              | Increased/Decreased Libido |

Other symptoms not listed above \_\_\_\_\_

When did these symptoms begin? \_\_\_\_\_

Are they getting worse? \_\_\_\_\_ better? \_\_\_\_\_ same? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Are you on/ or ever been on hormone replacement therapy? \_\_\_\_\_ If so, how long \_\_\_\_\_

Other medications/herbal remedies \_\_\_\_\_

Age of Mother at menopause: \_\_\_\_\_ Concerns/Experience \_\_\_\_\_

Additional Comments:

*Please read and sign:*

**I understand that payment is due at the time of treatment unless prior arrangements have been made.**

**I agree to give at least 24-hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy. Full payment of missed session will be billed without 24-hours notice of cancellation.**

**I understand the treatment here is not a replacement for medical care.**

**I understand the practitioner does not diagnose medical illness, disease or any other physical or mental conditions.**

**I have stated all my known conditions and take it upon myself to keep the practitioner updated on my health.**

**I understand that this information will be used for the purpose of my healing benefits. All information shared with my practitioner will be held in utmost confidentiality.**

Client signature \_\_\_\_\_ Date \_\_\_\_\_