



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 _____

Any Major Illnesses? _____

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? _____ cups/day _____

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

Circle and describe symptoms as applicable

- Family History of Prostate Disease? _____ Type _____ Relationship _____
- History of sexually transmitted disease? _____ When? _____ Type? _____
- Rate your interest in sex: high _____ moderate _____ low _____ none _____
- Do you have or have you ever had difficulty experiencing orgasm? _____
- Have you had a history of rape? _____ trauma? _____ incest? _____ If so, when? _____
- Did you undergo counseling for this? _____

URINARY SYMPTOMS (circle those applicable)

- Painful urination Bladder/Kidney Infections
- Frequent urination Nocturnal Urination/Frequency _____
- Changes in urinary system (describe flow, stream, strength of stream) _____
- When did you first notice these symptoms? _____
- Are they getting better or worse? _____

ERECTILE FUNCTION (circle symptoms)

- Difficulty obtaining an erection Difficulty maintaining an erection Painful ejaculation
- Is there a history of back injury/trauma? _____ Describe: _____
- When did you first notice symptoms? _____ Are they better or worse? _____
- Results of PSA (prostate specific antigen) test if known _____ date of test _____
- Results of sperm count (if applicable and known) _____ date of test _____

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.

Client signature _____ **Date** _____