



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 _____