CONFIDENTIAL CLIENT INTAKE FORM

Name:_____**Date of Initial Visit**_____

Address_____**State**_____**Zip**_____

Home Phone_____**Work Phone**_____**email**_____

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?_____**What brought it on?**_____

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

Alive? ***Age/Cause of Death*** ***Major Health Issues***

Mother:_____

Father:_____

Siblings:_____

Maternal Grandmother_____

Maternal Grandfather_____

Paternal Grandmother_____

Paternal Grandfather_____

Family History of Abuse_____***circle if applicable*** **: physical emotional sexual spiritual**

Family History of Substance Abuse_____**Suicide**_____ **Other Trauma**_____

DIGESTION & ELIMINATION

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____**Water Intake(glasses/day)**_____**Caffeine**_____

What is the worse thing on your diet_____**What foods are your weakness**_____

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?**_____

Other concerns_____

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:_____**Where are you?**_____

Do you pray to or have a spiritual practice_____

On a scale of 1 – 10 ***(1 being the lesser, 10 the greater*****) Please rate yourself:**
Faith_____**Hope**_____**Charity**_____**Generosity**_____ **Sense of Humor**_____
Sense of Fun_____**Fear**_____**Grief**_____**Other (describe briefly)**_____

What are hobbies/ 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:**_____

Phone_____**email**_____

Current Medications:_____

_____

Allergies: specify allergen and reaction:_____

Supplements/Remedies_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____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 you are *Currently* experiencing
Underline and 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

MALE ~ REPRODUCTIVE HEALTH HISTORY

Check and Describe those symptoms as applicable

Headaches: Migraine_____Tension_____Cluster_____Low back pain_____ Sore heels_____
Varicose Veins _____ Location_____
Numbness in legs/feet

Family History of Prostate Disease:____Type_____Relationship_____

Family History of Cancer_____Type_____Relationship_____

History of sexually transmitted disease_____When_____Type_____

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest__If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

Urinary Symptoms (circle those applicable)

Painful urination **Bladder/Kidney infections**
Frequent Urination **Nocturnal Urination/ Frequency_____**
Changes in urinary stream (describe flow, stream, strength of stream)_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Erectile Function(describe as indcated)

Difficulty obtaining an erection **Difficulty maintaining an erection** **Painful ejaculation**

Is there a history of back injury/trauma_____Describe:_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Current Medications or Supplements:_____

_____

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____
AdditionalComments: