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

FEMALE ~ 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*_____

Medications your mother took when she was pregnant with you (if any)_____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis------
Cancer(type)_____Menstrual Problems Menopause PMS

Method of Contraception (circle) pills patch diaphram 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 as appropriate:

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

Other Symptoms *(Circle and Describe as indicated)*

Varicose veins of leg
Numb legs and feet when standing still
Low back ache
Constipation
Endometritis
Fibroids (Size and Location if known)_____
Uterine infections
Bladder infections
Vaginitis
Chronic miscarriages
Weak newborn infants
Incompetent cervix
Pelvic Inflammation
Tired weak legs
Sore heels when walking
Painful intercourse
Endometriosis
Uterine Polyps
Frequent urination
Vaginal discharge (describe)
Vaginal Yeast infections
Premature deliveries
Difficult pregnancy
Spotting with pregnancy
Sexually Transmitted Disease (date and type)_____

Dry vagina (without menopause) **Difficult menopause**
Cancer(cervix, bladder, uterus, ovarian, bladder, bowel) **Cysts (ovarian breast)**

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Are you under the treatment for Infertility_____Describe current treatment to date :_____
(IUI, IVF,etc)_____

Gynecological Provider:_____Address_____Phone_____

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_____

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_____Last Menstrual period_____

Are you on/ or ever been on hormone replacement therapy?_____if so, how long_____

Name and dose_____

Reason for stopping_____

Other medications/herbal remedies_____

Age of Mother at menopause:_____Concerns/Experience_____

Additional Comments: