



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 | 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) _____ |

