Confidential Intake Form

Date of Initial Visit:

Name:

Address:

Home Phone: Work Phone

Mobile

Email

Date of Birth

Occupation

Marital/Relationship status

Referred by

Client Confidentiality Release Form I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy. I understand the treatment here is not a replacement for medical care. I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice) As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals. I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature_____Date_____

Primary reason for visit:

When did you 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

Have you had massage/bodywork before?

Medical History:

Are you currently under the care of another health care provider(s)?

Practitioner

Address:

CBD Phone

Email

Current Medications and /orSupplements

Remedies:

Prenatal supplements

Allergies:

specify allergen and reaction:

Hospitalizations Y N Accidents or Traumas Y N

Falls/Injuries to Sacrum/head/tailbone (describe)

Other: Do you use Tobacco? Y N Quantity /ppd

Alcohol? Y N Quantitiy ounces/ day

Marijuana? Y N Quantity Other:

Have you been under treatment for substance use?

Please review and check the following:

Headaches Type:

Pins and Needles in arms legs hands feet

Asthma Spinal Problems Anxiety Swollen ankles Depression

Sinus Conditions Frequent Colds Sleep Disturbance Seizures

Fainting Spells Loss of smell or Taste Loss of Memory

Skin Disorders:

Type Varicose Veins Hemorrhoids

Muscular Tension:

Location: Painful/Swollen Joints Herniated/Bulging Discs

High or Low Blood Pressure Sciatica Contact Lenses

Dentures/Partials Artifical/Missing limbs cold hands and feet

Digestion and Elimination:

Typical Breakfast:

Typical Lunch:

Typical Snacks:

Afternoon snack

Water Intake(glasses/day)

What is the worst item in your diet :

What foods are your weakness :

Are you subject to binge eating? Y N What foods :

Do you experience bloating/gas/burps after eating? Y N

What foods trigger this?

How often are your bowel movements?

Do your stools: sink float Constipation Blood 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

Describe your exercise routine (type, frequency)

What changes would you like to achieve in 6 months:

One Year:

Female Reproductive Health History

When did you begin your menses?

What was this like for you?

How many Pregnancy (s) have you had?

Number of Birth (s) Dates

Termination(s) When

Miscarriage(s) When

Complications

What was your experience of:

Pregnancy Labor

Birthing Post Partum

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

Birth Trauma (if known)

Method of Contraception (tick) pills patch diaphram

injection condoms IUD abstinence rhythm method

fertility awareness

Length of time using method

Last Pap smear

Results (if known)

Date of Last Menstrual period

Length of Menses

Are you Pregnant/Trying to Conceive? Y N

Episodes of Amenorrhea When For how long

Are you under the treatment for Infertility? Y N

Describe current treatment to date :

(IUI,IVF,etc) Gynecological Provider:

Address

Rate your interest in Sex:

High moderate Low None

Do you have or ever had difficulty experiencing orgasms? Y N

Have you experienced a history of rape trauma incest

If so,- when Did you undergo counseling for this? Y N

What was this like for you?

Please check as appropriate:

Painful Periods Irregular Cycles (early or late)

Dark, thick blood at beginning of cycle cycle

Dark thick blood at the end of cycle Headache or Migraine with period

Dizziness with period Bloating/Water Retention with period

Heaviness in pelvis with period PMS/Depression with or before period

Excessive Bleeding (> one pad/hour) Failure to Ovulate

Painful Ovulation Tired weak legs Numb

legs and feet when standing Sore heels when walking Low back ache

Painful intercourse Constipation Endometriosis Endometritis/Uterine

Infections Uterine Polyps Fibroids Vaginal Discharge/Vaginitis/ Bladder

Infections/Incontinence Chronic Miscarriage

Weak newborn infants Premature deliveries Spotting with pregnancy

Pelvic Inflammation Sexually Transmitted disease

Dry Vagina Difficult menopause Cancer esp of reproductive area

Cysts esp breast/ovarian Incompetent cervix

Maternal Family History of (please tick):

Infertility Fibroids Endometriosis PMS Menopause

Cancer(type) Menstrual Problems Other

Menopause Age symptoms began:

Are they getting worse better same

Are you on/ or ever been on hormone replacement therapy? Y N

if so, how long Name and dose

Reason for stopping

Age of Mother at menopause:

Concerns/ Experience