CONFIDENTIAL CLIENT INTAKE FORM

Date of Initial Visit: _____

Name: _____

Street Address_____

City_____State_____Zip_____

Home Phone_____email_____

Date of Birth:_____Age:_____Occupation_____

Date of last menstrual cycle:_____

Any known allergies to oils/essential oils/herbs? Y N If so, please note_____

On medications?_____Received prior massage/bodywork? Y N Indicate types:_____ Referred by: _____

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

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 school?_____ sleep?_____ recreation?_____

Describe your exercise routine (type, frequency)_____

FAMILY HISTORY

Mother: Alive Age:____ Deceased Age:_____How long ago?_____ Major Health Issues:_____

Father: Alive Age:____ Deceased Age:_____How long ago?_____ Major Health Issues:_____

Siblings: List in descending order:_____

Any Major Health Issues?_____

Your Birth Order: Eldest Middle Youngest

MEDICAL HISTORY

Current

Medications:_____

Allergies: specify allergen and reaction:

_____

_____

Supplements/Remedies_____

_____

_____

Surgical History (year and type):_____

Hospitalizations:_____

Accidents or Traumas:_____

Falls/injuries to sacrum/head/tailbone

(describe)_____

Birth Trauma if

known:_____

If you are CURRENTLY experiencing any of the following, please CIRCLE

If you have experienced any of the following in the PAST, please UNDERLINE

Headaches (migraine, tension, cluster)	Asthma	Sinus Conditions
Ringing in Ears	Swollen Ankles	Sciatica
Pins and needles in arms, legs, hands or feet	Seizures	Painful joints
Cold Hands or Feet	Anxiety	Fatigue
Loss of Smell or Taste	Spinal problems	Fainting spells
Skin Disorders (acne, fungus, psoriasis, other)	Loss of memory	Depression
Trouble sleeping	Contact lens	
Frequent colds/upper respiratory conditions	Dentures	
Muscular tightness (location)_____	Swollen joints	
Varicose Veins (location)_____		

Self Care

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?_____

If so, 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?_____mucus in stool?_____ Pain when stooling?_____

Other concerns:_____

_____

Emotional & Spiritual

What is your opinion of yourself?_____

Please describe the most negative emotion you experience_____

When do you most often feel this emotion?_____ Typically, where are you?_____

Do you pray or have a spiritual practice?_____

On a scale of 1-10 (1 being the lesser, 10 the greater), please rate yourself in the following areas:

Faith_____ Hope_____ Charity_____ Generosity_____ Sense of Humor_____ Sense of Fun_____

Fear_____ Grief_____ Other (please describe)_____

What hobbies/activities provide you with a sense of pleasure and accomplishment?_____

What are ways in which you take care of yourself?_____

What changes would you like to achieve in 6 months?_____One year?_____

FEMALE REPRODUCTIVE HEALTH HISTORY

Age of Menarche_____What was this like for you?_____

Date of Last Menstrual Period: _____ Length:_____

Cycle length:_____ Episodes of amenorrhea (no menses)? Y N If yes, when & how long?_____ Any known medications your mother took when she was pregnant with you?_____

Maternal Family History (circle): infertility fibroids endometriosis cancer (type):_____ menstrual problems Menopausal symptom(s) (type):_____ PMS (type):_____

Menses Difficulties: (circle if currently experiencing; underline if experienced in past)

Painful periods
Dark thick blood at beginning/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 & describe if currently experiencing; underline if experienced in past)

Varicose veins of leg
Numb legs and feet when standing still
Low back ache
Constipation
Uterine infections
Bladder infections
Vaginitis
Tired weak legs
Sore heels when walking
Painful intercourse
Endometriosis
Frequent urination
Vaginal discharge (describe)