REGENERATIONSPRINGS

23198 Brook Forest Road, Abita Springs, LA 70420
985-893-4456

CONFIDENTIAL CLIENT INTAKE FORM (W)

Name:_____ Date of Initial Visit:_____

Date of Birth: _____ Age: _____ Occupation: _____

Marital Status: Single Married Divorced How long?_____

Children: Y N Indicate sex, age, health issues and if still living at home: _____

Address: _____ City, State, Zip _____

Home Phone:_____ Cell phone: _____email:_____(will not be shared)

Received prior massage/bodywork? Y N Indicate types: _____

Are you allergic to any products that may be used on your skin? Specify allergen and reaction: _____

_____Referred by: _____

Specify current medication and reason for taking:_____

_____

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

When did you first notice your concerns?_____

What was happening at or just before the time your first noticed?_____

Describe what you think may have brought it on and any stressors occuring at the time:

What activities provide relief? _____What makes it worse? _____

Is this condition getting worse? _____Interfere with work? _____Sleep?_____Recreation?_____

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)? Y N Reason:_____

Surgical History (year & type):_____

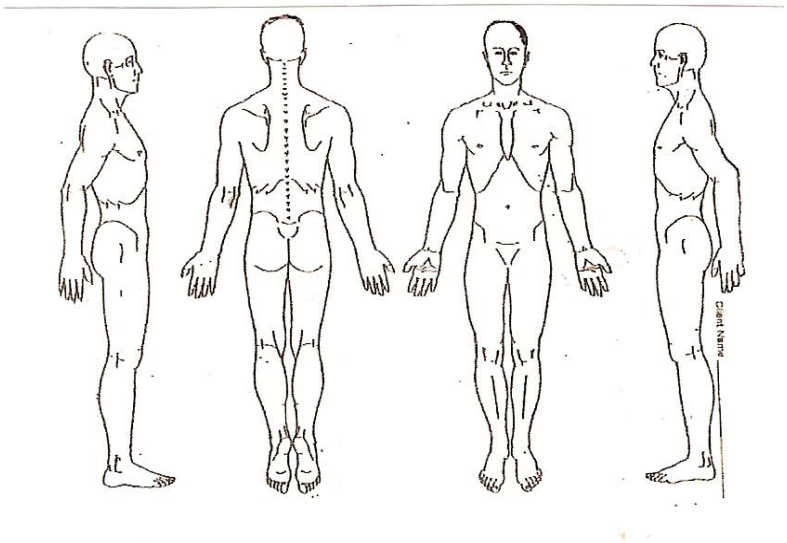
Hospitalizations: _____

Accidents or traumas: _____

Falls/injuries to sacrum/head/tailbone (describe):_____

Birth trauma if known: _____

Mark any areas of current persistent pain or tension on the figures below:



The following symptoms are used as guidance and not viewed as "something wrong." If you experience any of the symptoms presently (or in the recent past), please mark by indicating past or present, frequently or infrequently:

Digestion

Acid foods upset
Bad breath
Burning stomach relieved by eating (excess)
Stomach bloating
Lower bowel gas after eating
Foul smelling gas
Indigestion soon after eating
Frequent sour stomach
Loss of taste for meet
Frequent vomiting (excess)
Greasy Foods upset
Nervous stomach
Queasy with headache over eyes

Elimination

Burning/itching anus (parasites/food sensitivity)
Alternating constipation/diarrhea
Stools soft and/or watery
Irritable bowel
Use of laxatives
Painful bowel movements
GI ulcers
Stools light colored
Boils
Fungus
Acne
Psoriasis
Itching
Respiratory disorders

Viscera

Painful breasts
Skin peels on foot soles
Difficulty swallowing
Bitter, metallic taste in mouth in mornings
Pain between shoulder blades
Gall stones

Blood Sugar

Excessive appetite
Lightheaded & feeling of hunger
Get shaky if hungry
Eat when nervous
Irritable before meals
Fatigue relieved by eating
Afternoon headaches
Wake in night and can't get back to sleep (adrenal)
Moods of depression
Crave sweets
Headaches upon rising; wear off during day
Diabetes

Cardiac/Circulation

Swollen ankles worse at night
Bruise easily
Ringing in ears
Tension/tightness under sternum
Dizziness
High Blood Pressure
Low Blood Pressure
Varicose Veins : Location_____
Headaches: Cluster/migraines/tension

Muscles/Joints/Skeletal
Painful joints
Low back ache
Upper back ache
Fibromyalgia
Sciatica
Spinal problems
Artificial limbs
Arthritic

Endocrine
Get chilled often
Cold hands/feet
Flush easily
Irritated by strong light
Slow to wake and get started
Perspire easily
Sigh frequently
Get drowsy often
Mental sluggishness
Chronic fatigue

Salt craving
Unable to relax
Startle easily
Tendency to asthma/allergies
Decreased sugar tolerance
Weight gain around hips and waist

Food/environmental sensitivity
Eyes/Nose Watery
Eyelids Swollen/puffy
Sneezing attacks
Nightmares (histamine reaction)
Pulse speeds after meals

Mineral/Vitamin/EFA deficiencies

Dry skin/ mouth/eyes/nose
Burning/itching skin and/or feet
Excessive hair loss/course hair
Frequent skin rashes
Reduced appetite
Sensitive to hot weather
Constipation
Tendency to hives
PMS
Painful Menses
Depression before menses
Leg nervousness at night
Neuralgia-like pains
Hands & feet go to sleep easily; numb
Worrier
Heart pounds after retiring
Failing Memory
Pulse below 65
Heart palpitations
Irritable and restless
Can't work under pressure
Insomnia
Nervousness
Highly emotional
Eyelids/face twitch
Hair loss
Nails weak/ridged
Cuts heal slowly
Joint stiffness after rising
Muscle/leg/toe cramps at night
Muscle cramps worse during exercise
Anemia
Night sweats

MALE REPRODUCTIVE HEALTH HISTORY

CIRCLE if currently experiencing, UNDERLINE if experienced in the past

Headaches (migraine, tension, cluster)	Low back pain	Sore heels
Varicose veins: location	Numbness in legs/feet	Depression
Anxiety	Irritability	Easy to anger
Painful urination	Bladder/Kidney infections	Frequent urination
Nocturnal urination/frequency_____	Changes in urinary stream	
Difficulty maintaining an erection	Painful ejaculation	

When did you first notice these symptoms? _____Are they getting better or worse? _____

Describe:_____

Are you taking any current medications or supplements for these symptoms? _____

If so, what kind? _____ Concerns/experience _____

Is there a history of back injury/trauma? _____ Describe: _____

Results of PSA (prostate specific antigen) Test if known:_____ Date done: _____

Results of sperm count (if applicable and known)_____Date done: _____

Family History of Prostate Disease Y N Type:_____Relationship:_____

Family History of Cancer Y N Type:_____Relationship:_____

History of Sexually Transmitted Disease Y N Type: _____Date:_____

Are you under treatment for infertility? Y N Describe current treatment:_____

Rate your interest in sex: High Moderate Low None Do you experience pain upon intercourse? Y N

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

Have you experienced a history of: rape trauma incest emotional abuse If so, when?_____

Did you undergo counseling for this? Y N What was this like for you? _____

Additional comments:

Family History

	Still Living?	Age/Cause of Death	Major Health Issues
Mother			
Father			
# of Siblings Your Birth Order? Youngest, Middle, Eldest			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			

Paternal Grandfather			

Family History of Abuse: Y N circle if applicable: physical emotional sexual spiritual

Family History of Substance Abuse: Y N Suicide: Y N Other trauma:_____

Personal History: Do you use: Tobacco?_____ /ppd Alcohol?_____ounces/day/week/month

Marijuana?____Other self medications?_____Treated for substance abuse? Y N Describe_____

Please check each item that is included in your usual diet:

__red meat	__soy	__vitamin supplements	medicines:
__fish	__dairy products	__protein supplements	__birth control pills
__poultry	__black tea	__herbal supplements	__hormone therapy
__fruit	__herbal tea	__sugar	__aspirin
__vegetables	__ alcohol	__yogurt or Keifer	others: list
__raw foods	__coffee	__fermented foods	
__nuts & seeds	__tobacco	__sodas (diet or regular?)	

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner:_____

Snacks:_____Water Intake (glasses) _____

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

Diarrhea_____ Constipation?_____Blood in stool?_____mucus in stool?_____ Pain when stooling?_____

Supplements:_____

Other diet concerns:_____

What is your exercise routine?_____

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?_____

Please read and sign

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 therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions.

I understand the treatment here is not a replacement for medical care, nor is it a substitute for medical treatments and/or diagnosis and it is recommended that I see a qualified professional for physical or mental conditions that I may have.

I understand the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does she perform any spinal manipulations.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client Signature_____Date_____

Therapist/Practitioner signature_____Date_____

Client Confidentiality Release Form

I, (name) _____, give my permission for my therapist/practitioner DONNA CAIRE, to take notes about me, including health history, medical and/or personal information I choose to disclose to her. I understand that this information may be used anonymously when consulting with other MAM practitioners.

Signature: _____Date_____