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: _____

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

_____

Address: _____ City, State, Zip _____

Contact Phone:_____email:_____(will not be shared)

Occupation:_____

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: _____

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

When did you first notice your concerns?_____

Describe what was happening at or just before the time your first noticed your symptoms. Was there an emotional upset, a fall, an accident, an illness, etc? If lifelong, recall first memory of concern:

Is this condition getting worse? _____Interfere with work? ___Sleep?_____Recreation?____

What activities provide relief? _____

What activities make it worse? _____

Specify medication/herbal remedies currently taking and reason for taking:_____

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:

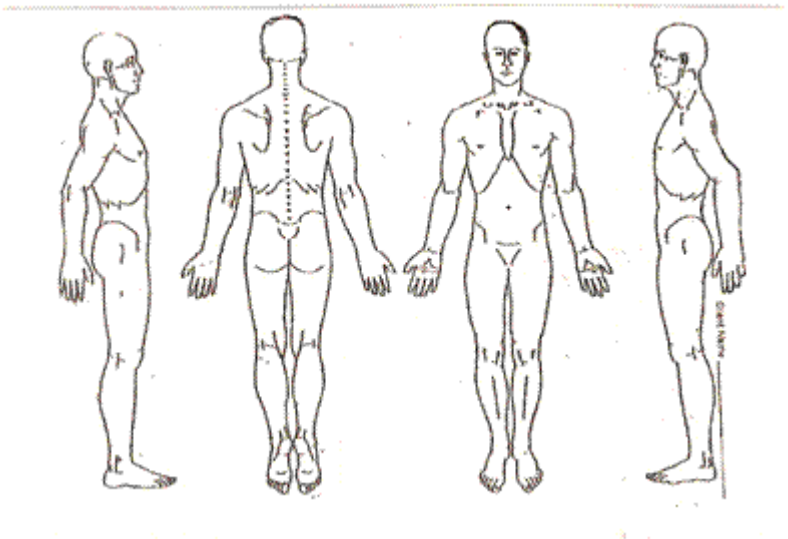
Organs surgically removed (Please note year of removal, your age at the time, organ, reason for removal, your concerns before and after):

Other surgical history (Please note year, your age, reason for surgery, your concerns before and after):

Accidents or physical traumas (include falls/injuries to sacrum/head/tailbone) (Please note year, your age, & description, your concerns before and after):

Birth trauma if known: _____

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



FEMALE REPRODUCTIVE HEALTH HISTORY

Write a brief description of your reproductive health: What age did you begin to menstruate? What was this like for you?

Are you still menstruating? If you aren't, what age did you stop? What is this like for you?

Is/was your menses regular? How many days between cycles? How long is a typical bleed?

Do or did you have menstrual challenges, such as no menses, severe cramping, etc? (if so, please explain):

What is (was) your method of contraception? How long?

Have you had irregular paps?

Any known medications your mother took or complications when she was pregnant with you?_____

Do you have maternal family history of: infertility fibroids endometriosis PMS menopausal symptom(s) (type): _____ cancer (type):_____?

Are you pregnant? Y N How many weeks: Due date:

Describe your emotional and physical health during this pregnancy and any prior pregnancies:

What was your experience of labor?
Delivery?
]Post Partum?

Did you nurse? How long? What was this like for you?

Have you experienced any terminations or miscarriages?
What was your age(s) at the time, and do you feel like you have fully explored these events?

Have you been under treatment for infertility? Y N Describe current treatment to date (IUI, IVF, etc): _____

In a brief paragraph, describe physical/emotional symptoms of menses/menopause you experience. Please include when symptoms began, and if you noticed any event surrounding this time, whether symptoms are getting better or worse, and if you are taking any medications/herbs for these symptoms.

In addition, please respond to questions below with yes/no or circle any symptoms below if they apply:

Are your cycles short (less than 28 days) or long (more than 28 days)?
What is the color of your menses: bright red dark red brown other:
Do you have dark thick blood at *the beginning or the end* (circle one) of cycle?
Do you experience light, heavy or excessive bleeding (>one pad/hour)?

Is your menses painful? What does it feel like, i.e. feels like uterus forced down from above, cramping, other:

Do you feel stiffness or pain in your lower back before your menses? Is it relieved or aggravated by menses? How long does it continue?

Do you get headaches/migraines/dizziness associated with menses? Describe:

Do you get PMS/depression/food cravings associated with menses? Describe:

Do you get bloating/water retention associated with menses? Describe:

Do you have body awareness of ovulation? Describe:

Do you experience varicose veins, tired or weak legs, numb legs and feet when standing, sore heels when walking? (Please circle)

Do you experience constipation and/or diarrhea associated with menses?

Hot flashes	Mood Swings	Vaginal Discharge	Cancer
Dry Vagina	Vaginitis	Painful intercourse	Spotting
Depression	Anxiety	Bladder infections/incontinence	Endometriosis
Irritability	Fatigue	Disturbed sleep	Hemorrhoids
Memory loss	Increased libido	Decreased libido	Fibroids/Polyps
Cysts (breast, ovarian, uterine)		Clotting	Other:
Sexually transmitted disease		Pelvic inflammation	

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

If so, how long?_____ Name and dose _____

If stopped, reason? _____

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 or sexual abuse? How old were you at the time? Did you undergo counseling for this at the time? Leter?
Did you find it helpful? How are you currently experiencing the emotions surrounding the abuse?
I realize these are very personal questions, but the reason I ask them is because our organs store emotional memories, and when massaging the abdomen, these emotions can surface. It is good to be prepared to acknowledge these emotions so they can be released.

Additional comments:

Digestive Health

Describe your eating habits (include a typical breakfast, lunch, dinner and snacks)

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

__red meat	__soy	__vitamin supplements	__aspirin
__fish	__dairy products	__protein supplements	__other self
__poultry	__black tea	__herbal supplements	medications?
__fruit	__herbal tea	__sugar	
__vegetables	__ alcohol	__yogurt or Keifer	
__raw foods	__coffee	__fermented foods	
__nuts & seeds	__tobacco	__sodas (diet or regular?)	

How much water do you drink? Intake (glasses) _____ Other beverages (please list)
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? _____
Stools: sink float diarrhea constipation Blood in stool? mucus in stool? Pain when stooling? Color of feces?

Supplements(brand, amount, kinds) _____

Other diet concerns:_____
What is your exercise routine?_____

Please circle if currently experiencing

Digestion

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

Elimination

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

Viscera

Painful breasts
Bitter, metallic taste in mouth in mornings
Gall stones
Difficulty swallowing
Pain between shoulder blades

Respiratory/Skin disorders

Fungus
Psoriasis
Asthma
Frequent sore throats
Skin peels on foot soles

Cardiac/Circulation

Swollen ankles worse at night
Bruise easily (location)
Ringing in ear
Tension/tightness under sternum
Dizziness
Varicose veins (location)
Low Blood Pressure
High Blood Blood Pressure

Blood Sugar

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

Muscles/Joints/Skeletal

Painful joints
Low back ache
Upper back ache
Spinal problems
Arthritic
Fibromyalgia
Sciatica
Artificial limbs

Endocrine

Get chilled often
Cold hands/feet
Flush easily
Irritated by strong light
Slow to wake and get started
Perspire easily
Sigh frequently
Mental sluggishness
Weight gain around hips and waist
Decreased sugar tolerance
Tendency to asthma/allergies
Startle easily
Unable to relax
Salt craving
Get drowsy often
Chronic fatigue

Food/environmental sensitivity

Eyes/Nose Watery
Eyelids swollen/puffy
Sneezing attacks
Pulse speeds after meals
Nightmares (histamine reaction)

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
Night sweats
Anemia
Muscle cramps worse during exercise
Muscle/leg/toe cramps at night
Joint stiffness after rising
Cuts heal slowly
Nails weak/ridged
Hair loss
Eyelids/face twitch
Highly emotional
Nervousness
Insomnia
Can't work under pressure
Irritable and restless
Heart palpitations
Pulse below 65

Emotional & Spiritual

What do you feel about yourself emotionally and spiritually? Do you feel like you are in a good place?

Do you experience more negative or more positive emotions? What positive emotions do you experience most often?
What negative emotions do you experience most often?
When do you most often feel these emotions?_____ Typically, where are you?_____

Do you pray or have a spiritual practice?_____
Do you feel the need to self medicate with alcohol or drugs on a frequent basis?

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?_____

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:_____

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_____