Make yourself a cup of tea.
Find a quiet and calm place to sit.
This is a time to recenter and check in with yourself.

Thank you for making the time to take care of you.

Confidential Intake Form

Name: ______________________________ Date of Initial Visit: ___ /___ /___

Date of Birth: ___ /___ /___ Age: ______ Preferred Pronouns: ____________________

Address: ________________________ City: __________ State: ___ Zip: __________

Home Phone: (___) ___ - _____ Work: (___) ___ - _____ Cell: (___) ___ - ______

Email: ____________________ Occupation: ______________________________

Marital/Relationship Status: ________________ Referred by: ____________________

Client Confidentiality and Confidentiality Release

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under their professional scope of practice. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the practitioner updated on my health. Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The practitioner maintains a copy for their records, and clients may also request a copy of the form they signed.

I, (Print Name)

give my permission for my practitioner, to take notes including health history/medical and/or personal information I choose to disclose to them.

Client Signature: ______________________________ Date:___ /___ /___

Practitioner Signature: ______________________________ Date:___ /___ /___

Reason for Visit

Primary reason for visit: ____

When did your first notice it? ____

What idea do you have about what brought it on? ____

Describe any stressors occurring at the time: ____

What activities provide relief? ____

What makes it worse? ____

Is this condition getting worse? ____

Does it interfere with: Work ____ Sleep ____ Recreation _____

Have you had massage/bodywork before? ________ What type? ________________________________

Medical History

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

Reason(s): ____

Name of Practitioner: ____ Phone: (___) ____ - ______

Name of Practitioner: ____ Phone: (___) ____ - _______

Current Medications, Supplements, Herbal Remedies: _______________________________________

____

____

Allergen and your Allergic Reactions: ____

Surgical History (include cosmetic surgeries) Year and Type: __________________________________

____

Hospitalizations: ____

Accidents or Traumas: ____

Falls/Injuries to Sacrum/Head/Tailbone (describe): ____________________________________

General Health

Which of these have you experienced?

Past	Present		Past	Present	
○	○	Headaches *Type/Location:* ____________	○	○	Skin Disorders *Type:* ______________________
○	○	Muscular Tension *Location*: __________________	○	○	Varicose Veins *Location*: __________________
○	○	Numbness in feet or legs	○	○	Herniated/Bulging Discs
○	○	Asthma	○	○	Painful/Swollen Joints
○	○	Sore heels when walking	○	○	Artifical/Missing limbs
○	○	Cold Hands or feet	○	○	Low Back Pain
○	○	Anxiety	○	○	Fainting Spells
○	○	Swollen ankles	○	○	High or Low Blood Pressure (circle)
○	○	Depression	○	○	Seizures
○	○	Sinus Conditions	○	○	Cancer *Type:* _________________________ *PastTreatment:* ________________ *CurrentTreatment:* ______________
○	○	Frequent Colds			
○	○	Trouble falling asleep			
○	○	Trouble staying asleep			
○	○	Hemorrhoids			

Known Biological Family Medical History

Start two generations back and include siblings.

	Relation to you	Still Living?	Cause of Death	Age	Major Health Issues
1					
2					
3					
4					
5					
6					
7					

Food Diary

Please log your food intake for three days prior to you appointment.

DAY ONE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY TWO

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY THREE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

Digestive Health

What dietary restrictions do you have? ____

Water Intake (glasses per day): ____________________ Caffeine (type/amount): _____________

Are you subject to binge eating? _____ What foods? ___________________________________

Do you experience burps, bloating, or gas after eating? (circle) _____ What foods trigger this? _________

Do you use Tobacco? ___ How much / How often? _____________________________________

Alcohol? ___ How much / How often? ____

Marijuana? ____ How much / How often? _______________ Other: __________________

Have you been treated for substance use? ____

How often are your bowel movements? ______________

Do your stools: Sink ____ Float ____ Constipation? _____ Diarrhea? _______

Blood in stool ? ____ Mucus in stool? ____ Pain when stooling? ____ Other ___________________

Emotional & Spiritual Health

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 or have a spiritual practice? ____

If so, what do you pray to? ____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) please rate yourself in each of these qualities:

Faith ____ Hope ____ Charity ____ Generosity ____ Sense of Humor ____ Fear ____ Grief ____

Sense of fun ____ Other (describe briefly) ____

What hobbies/activities provide you with pleasure and accomplishment? _____________________

Describe your exercise routine (type, frequency): ________________________________

What changes would you like to achieve in 6 months? ____________________________

Reproductive Health

Please fill out all that applies to you.

Are you trying to conceive? _________ Are you possibly pregnant? ___________________________

Are you being treated for difficulty becoming pregnant? ______________________________________

Describe treatment(s) to date (IUI, IVF, etc) : ____

Method of Contraception (circle) : Pills Patch Injection Diaphragm Condoms

IUD Abstinence Pulling out Fertility Awareness (Charting)

Other: ______________________ Length of time using method: ______________________________

Last Pap smear: ________ Results: ____

Menstruation

Age of first period: _____ What was this like for you? ____

Last start date of period: ____________________ Length of monthly cycle : ________________________

	Past	Present		Past	Present
Painful Periods	○	○	Uterine or Cervical Polyps	○	○
Irregular cycles: *Early ___ Late ___*	○	○	Fibroids *Location (if known): __________*	○	○
Heavy Pelvis before Menses	○	○	Uterine Infection(s)	○	○
Dark Thick Blood (circle): *Beginning End Both*	○	○	Missed periods *How long? __________*	○	○
Excessive Bleeding *Pads/Hour: __________*	○	○	Cysts *Location (if known): __________*	○	○
Headache or Migraine w/ menses	○	○	Bladder Infection(s)	○	○
Dizziness	○	○	Vaginal/Genital Infection(s)	○	○
Bloating	○	○	Urinary Incontinence	○	○
Water Retention	○	○	Painful Intercourse	○	○
Painful Ovulation	○	○	Vaginal/Genital Dryness	○	○
No Ovulation	○	○	Sexually Transmitted Disease *Type: __________*	○	○
Endometriosis *Location (if known) : ____________*	○	○			

Pregnancy History

Current Pregnancy: Due Date: ________ Doctor/Midwife: ______________________________

Home/Hospital/Birthing Center: ______________________________

Total number of pregnancies: ____ Number of births: ____ Dates: ______________________________

Briefly describe your experience with:

Pregnancy: ______________________________

Labor: ______________________________

Birthing: ______________________________

Postpartum: ______________________________

Complications: ____ Miscarriages: ____ Terminations: ____ Premature births: __________

Spotting during pregnancy: ____ Weak newborn at birth: ____ Incompetent cervix : _____

Maternal Family History of (please circle):

Cancer (type): _________ Hysterectomy Other: _________

Medications you may have been exposed to in utero (if any): ______________________________

Did you have any trauma at birth? (if known) : ______________________________

Menopause

Do you experience any of the below?

Hot flashes	○	Dry Vagina/Genitals	○
Insomnia	○	Depression	○
Fatigue	○	Anxiety	○
Memory Loss	○	Irritability	○
Mood Swings	○	Spotting	○
Vaginal/Genital Discharge	○	Flooding *Pads/Hr:* ________________	○

Age symptoms began: ____ Are they getting worse? ____ Better ____ Same ______________________

Are you on or have you ever been on hormone replacement therapy? ______ How long?________________

Name and dose: ______________________________

Reason for stopping: ______________________________

Age of biological mother at menopause: ______ Concerns/Experience: ______________________________

Sexual wellbeing - please fill out to your comfort level

Rate your interest in Sex: Insatiable _____ High ___ Moderate ___ Low _____ None _____

Do you have or did you ever have difficulty experiencing orgasms? _________________________________

Do you have a history of: Rape ____ Trauma ____ Incest ____

If so, when? ___________ Did you undergo counseling for this? ______

Did you find counseling helpful? ____

Pelvic and Genital Issues and Pain

Pain or Discomfort in (circle) :

Penis Testicles Perineum Rectum Urinary Tract Labia Vagina Clitoris

Pain or Discomfort in groin or inner thighs (circle) : Left Right Both

Frequent infection in: UTIs ____ Bladder ______ Kidney ______ When? _________________________

Difficulty with arousal or erection (circle) :

Obtaining Maintaining Painful Painful ejaculation

Urinary Difficulty (circle) : Difficult starting Weak flow Interupted flow Painful Urination

Urinary Retention Bedwetting Nocturnal Urination (Times per night?): ___________

Do you have any sexually transmitted disease(s)? ____

Do you experience pelvic pressure? ______ Pain in lower back, esp after intercourse? ______

Family History of Prostate Disease: Yes ___ No___ Type: _________ Relationship to you: _______________

Results of PSA (Prostate Specific Antigen) Test if known: ______ Date : ____________________

Results of Sperm Analysis : Count : ____ Motility : ____ Morphology : ____ Date done: ____________

Additional information you feel important your practitioner should know that is not mentioned here:

____

____