Confidential Client Intake Form

Name:_____**Date of Initial Visit**_____

Address_____**State**_____**Zip**_____

Home Phone_____**Work Phone**_____**email**_____

Date of Birth_____**Age**_____**Occupation**_____

Marital/Relationship status_____**Referred by**_____

Have you had massage/bodywork before?_____ **What type?**_____

Reason For Visit

Primary reason for visit:_____

When did your 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**_____

Medical History

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

_____

Name(s) of Practitioner_____**Address:**_____

Phone_____**email**_____

Current Medications and /orSupplements/Remedies:_____

_____

Allergies: specify allergen and reaction:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Hospitalizations

_____

_____

Accidents or Traumas_____

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

Other:

 Please review and check the following:

Headaches Type:	Past	Present	Pins and Needles in arms, legs Hands or feet	Past	Present
Asthma			Spinal Problems		
Cold Hands or feet			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 Location		
Sciatica			Muscular Tension: Location:		
Painful/Swollen Joints			Herniated/Bulging Discs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artifical/Missing limbs		

Other (not mentioned above)

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day
Marijuana?_____Quantity_____Other:_____Have you been under treatment for substance use?

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Digestion and Elimination

Typical Breakfast:_____
–

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____**Water Intake(glasses/day)**_____**Caffeine**_____

What is the worst item in your diet_____**What foods are your weakness**_____

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

Do you experience bloating/gas/burps after eating?_____**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?_____

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**_____

MALE ~ REPRODUCTIVE HEALTH HISTORY

Check *and* **Describe** *those symptoms as* **applicable**

Headaches: Migraine_____Tension_____Cluster_____Low back pain_____Sore heels_____
Varicose Veins _____ Location_____
Numbness in legs/feet

Family History of Prostate Disease:____Type_____Relationship_____

Family History of Cancer_____Type_____Relationship_____

History of sexually transmitted disease_____When_____Type_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest__If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

Urinary Symptoms (*circle those applicable*)

Painful urination **Bladder/Kidney infections**
Frequent Urination **Nocturnal Urination/ Frequency_____**
Changes in urinary stream (describe flow, stream, strength of stream)_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Erectile Function(*describe as indicated*)

Difficulty obtaining an erection **Difficulty maintaining an erection** **Painful ejaculation**

Is there a history of back injury/trauma_____Describe:_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Current Medications or Supplements:_____

_____

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

AdditionalComments: