PURE MUSCLE THERAPY BY NICOLE, LMT #8227

HEALTH INTAKE QUESTIONNAIRE

Name:

D.O.B:

Phone:

E-mail:

ABOUT YOUR HEALTH

The human body is deisgned to be healthy. Throughout life, event occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, which have resulted in poor health. Through treatment sessions we will begin to correct these layers of damage and recover your innate health potential.

LOSS OF WELLNESS (BIRTH TO AGE 5)

Let's begin at birth when you may have first damaged your nerve system, lost your wellness and began your journey to ill health.

Was the birth long and/or difficult?	☐ Yes	☐ No
Were forceps or suction used?	☐ Yes	☐ No
Was the birth Cesarean (C-Section) ?	☐ Yes	☐ No
Were you born breech?	☐ Yes	☐ No

Comments regarding your birth:

Do you know any stressful situations that may have been present for your mother or father or both?

GROWTH AND DEVELOPMENT

Did you roll out of bed or have any falls as a child?	☐ Yes	☐ No
Any Childhood illnesses?	☐ Yes	☐ No
Did you have any other traumas?	☐ Yes	☐ No
Did you have colic, reflux, or difficulty feeding?	☐ Yes	☐ No

Please describe in more detail any of the above:

Were there any stressful events (0-5yrs)? ☐ Yes ☐ No
Please describe in more detail:

LOSS OF WHOLE BODY HEALTH (AGE 5 – PRESENT)

As you increase the layer of damage you probably begin to experience symptoms and random bouts of sickness.

Did you, or do you currently?:

Smoke tobacco products?	☐ Yes	☐ No	☐ Reformed Smoker
Drink Alcohol?	☐ Yes	☐ No	☐ Recovered Drinker
If yes, how often do you drink?	☐ Daily	☐ Weekly	☐ Occasionally
Recreational Drugs?	☐ Yes	☐ No	☐ Used Previously

Have you recently taken recreational drugs (this information is confidential) please list them along with the number of days/week since last taken.

Do you take over the counter drugs / medicine? ☐ Yes ☐ No Please list in box below:

Do you take prescription medicine? (please list & include function of the drug e.g. blood pressure, etc.)

How would you describe your diet? Do you eat healthy?

Have you been in any accidents? Please describe:

Have you had any surgeries? Any organ removals or transplants? Please list type of surgery & date:

How are your sleeping habits? (Trouble falling asleep, staying asleep, trouble upon waking, etc..)

Sleep Posture - check box(es):

Side Sleeper ☐ Back ☐ Stomach ☐

Did you previously or currently have any work-related stress? Please describe.

☐ Yes, Currently ☐ Previously ☐ No current stress

Any previous or current mental or physical stress? Please describe.

☐ Yes, Currently ☐ Previously ☐ No current stress

Do you have any current or previous injuries from hobbies and/or sports? Please describe.

☐ Yes, Currently ☐ Previously ☐ No

Any other traumas or experiences you feel may be relavent to your treatment and healing?

☐ Yes ☐ No

What is your relationship like with your mother?

What is your relationship like with you father?

CURRENT STATE OF HEALTH

What is your body telling you right now? What symptoms are you experiencing?
Please describe and explain what you feel is happening in your body.

When did this start? What do you think the cause is?

What activities aggravate your condition?

What lessens your condition?

Is this condition interfering with:

Sleep ☐ Check Box Work ☐ Check Box Daily Activities ☐ Check Box Other ☐ Check Box

What is stopping you from doing?

If this were to go away tomorrow, what would be different about your life?

Are you living the life you would like to be?

What are you looking to get out of this treatment?

On a scale of 1-10, how happy are you?
1 = complete unhappy, 10= happiest I've ever been

On a scale of 1-10, how much stress is in your life?
1 = none whatsoever, 10 = the most stress I've ever had

Please check any of the following symptoms you are currently experiencing:

☐ NECK PAIN	☐ STIFF NECK	☐ LOSS OF TASTE / SMELL
☐ SHOULDER PAIN	☐ HEADACHES	☐ ALLERGIES
☐ CHEST PAIN	☐ DIZZINESS	☐ COLD /FLU
☐ MID-BACK PAIN	☐ FAINTING	☐ MENSTRAUL PAIN
☐ LOW BACK PAIN	☐ EARS RINGING	☐ STRESS
☐ KNEE PAIN	☐ BALANCE LOSS	☐ FIBROMYALGIA
☐ SCIATICA	☐ MEMORY LOSS	☐ DEPRESSION
☐ NUMBNESS IN FINGERS	☐ MIGRAINES	☐ SHORTNESS OF BREATH
☐ NUMBNESS IN TOES	☐ NERVOUSNESS	☐ DIFFICULTY BREATHING
☐ PINS & NEEDLES (ARMS)	☐ TENSION & IRRITABILITY	☐ STOMACH / DIGESTIVE PROBLEMS
☐ PINS & NEEDLES (LEGS)	☐ FATIGUE / SLEEPING	☐ CONSTIPATION / DIARRHEA
☐ COLD HANDS & FEET	☐ CHRONIC FATIGUE	☐ WEIGHT PROBLEMS
☐ COLD SWEAT	☐ INSOMNIA	☐ FEVER
☐ LIGHT SENSITIVITY	☐ HEARING PROBLEMS	☐ THYROID ISSUES

Are you ready to make changes to your life in order to heal, even if these changes are inconvienent to your current lifestyle?

YES ☐ Check Box NO ☐ Check Box Unsure ☐ Check Box

- By signing this form, I consent to the healing work while I am receiving treatments.
- I understand that with any healing process and work on my body, my symptoms may worsen before they get better.
- I understand that this bodywork treatment is designed to help assist the body with healing to remove stressors from the body.
- I understand that healing takes time, that there is no quick immediate fix for my problems, and that health is a process.
- I have freely decided to undergo treatment and hereby give my full consent to receiving bodywork and Spinal Flow treatment.

Client Name: _____

Client Signature: _____ ☐ Check here to consent to a digital signature

Date: _____