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**PATIENT INTAKE FORM** **HOLISTIC HEALTH ASSESSMENT**

**Important: This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition. Thank you.**

Name: Gender: M F Date:

Home Address: City:

State:

Zip:

Email:

Birth date:

Age:

If under 18, person responsible for your account:

Home phone:

Work phone:

Cell phone:

Emergency Contact: Name: Contact phone:

Marital Status: single married divorced widowed with a significant other

Are you a caregiver for dependents? Yes No If yes, how many children? How many adults

Occupation: Number of years in this type of work:

Retired: Number of years in retirement: Occupation when in workforce *(please fill out the previous line)*

Primary care physician: Name: Phone:

How did you hear about us? *Please circle one and write the name* Current patient: Doctor:

Friend: Insurance:

Advertisement: Other:

## Please indicate if any of the following pertain to you: (indicating “yes” does not make you ineligible for treatment, however, it may restrict some of your treatment modalities)

hepatitis HIV high blood pressure seizures pacemaker blood-thinning meds

pregnancy Surgically implanted joint/bone replacement or stabilizers

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist, etc.)? Yes No

If yes, please provide the name and title of the practitioner(s), the condition being treated and the length of time you have been receiving this treatment:

Practitioner Condition Length of treatment to present



Please list all past medical conditions for which you were hospitalized and/or received surgery (include the dates).



## Current Health Concerns

Please list your health concerns in order of priority:

1.

2.

3.

What do you believe is causing your most important health concerns?



What is your main reason for today’s visit? How long have you had this condition? How does it impact your quality of life?

Have you seen a physician or other health practitioner about this? When?

What was the diagnosis (if any)?

Have any other family members had similar problems (describe)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any treatment you received and the results:



What aggravates this condition? What improves this condition?

**Client Description**

**Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_**

**Body Frame (S, M, L): \_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family/Living Situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-time, Part-time, Other: \_\_\_\_\_\_\_\_\_\_**

**Exercise/Recreation and # of times/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Hazards**

Describe any noticeable correlation between your problems and stress (work, family, relationships, financial).

List any toxicity—exposures and sensitivities to chemicals (tap water, air pollution, job and home exposures, cosmetics, food and chemical residues, e.g., Nutrasweet, and medicines including aspirin, birth control, etc.).

List any trauma (unresolved, physical and/or emotional wounds or abuse). What re-stimulates it? How does it affect your diet and health habits?

Describe any malnutrition (periods of eating junk food, binge eating, dieting).

List any addictive behaviors (past or present use and abuse of alcohol, drugs, tobacco, caffeine, codependency, workaholic, etc.).

**Dietary Habits and Choices**

What were your diet and family eating habits like growing up?

Describe your diet at the onset of your health problems.

How has your diet changed in relationship to your health problems? (Special diets?)

Describe the foods you eat (comfort foods) when you are:

1. Hungry:
2. Angry:
3. Lonely:
4. Tired:
5. Depressed:
6. Celebrating:

How is your mood and energy level affected by eating these foods (nourishing or numbing)?

## Lifestyle, Mood and Energy

How is your sleep? Can you get to sleep easily? Can you stay asleep?

***For women:*** How are/were your cycles? Do/did you have PMS? Painful periods?

How are your moods in general? Do you experience more anxiety that you wish? Depression? Anger?

On a scale of 1 to 10, 1 being the worst and 10 being the best, describe your usual level of energy (circle one): 1 2 3 4 5 6 7 8 9 10

What are your health goals?

## Habits and Lifestyle

Do you smoke?

If yes, what?

How much per day?

Since when?

Do you drink alcohol?

If yes, what?

How much?

How often?

Do you exercise regularly? If yes, please describe what you do:

Emotional stress scale *Please circle*

1 2 3 4 5 6 7 8 9 10

No Stress Moderate Extremely stressed

What do you do when you want to release stress and/or just relax?

How many hours do you usually sleep per night? When do you go to bed?

Do you wake feeling refreshed?

What is your height?

What is your present weight?

What was your weight one year ago?

What is the most you have ever weighed? When?

How often do you have a bowel movement?

## Nutrition

Do you drink coffee? If yes, how much per day?

Do you drink caffeinated tea? If yes, how much per day?

Do you drink soda pop? regular diet none *(Please circle one)* If yes, for how long? Do you have regular eating habits? Yes No

Do you eat while engaged in other occupations? Yes No

Do you eat more when under stress or feeling depressed? Yes No

Do you experience sudden drops in energy? Yes No If yes, when?

Please describe a typical day’s diet for you:

| Breakfast | Lunch | Dinner | Snacks(what hour?) |
| --- | --- | --- | --- |
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## Family History

Please describe your family’s health, including current age or age at death, and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

| **Member** | **Living?/Age** | **Major Illness or Chronic Conditions** |
| --- | --- | --- |
| **Mother** |  |  |
| **Father** |  |  |
| **Sisters/Brothers** |  |  |
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| **Maternal Grandmother** |  |  |
| **Maternal Grandfather** |  |  |
| **Paternal Grandmother** |  |  |
| **Paternal Grandfather** |  |  |

**WOMEN ONLY** *please circle response as appropriate*

Are you currently experiencing any gynecological symptoms or problems? Yes No

Any problems related to sexual function? Yes No

Do you have any history of sexually transmitted diseases? Yes No

Do you have any history of cervical, ovarian, or breast cancer? Yes No Do you perform regular breast self-exams? Yes No

How old were you at onset of first menses?

If you are of menstruating age: date of last period

periods generally last days and occur every days

bleeding is heavy moderate light

List any PMS symptoms:



If you are menopausal or perimenopausal:

Are you taking hormone replacement therapy? Yes No

List and symptoms or concerns:

\_ Number of pregnancies and your age at each Number of live births and your age at each:

Natural deliveries? C-sections?

Are you currently trying to conceive? Yes No

**MEN ONLY** *please circle response as appropriate*

Are you currently sexually active? Yes No If yes, partner(s) is/are male female If sexually active, do you perform safe sex practices? Yes No

Do you have any history of sexually transmitted diseases? Yes No

Have you ever had a diagnosis of prostate enlargement or cancer? Yes No

Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling)? Yes No Do you ever experience trouble with sexual function/libido? Yes No

## Symptoms

\*\*\* **For each symptom you currently have, please rate its severity from 1 to 5 (5 being the worst). Leave blank if not applicable.\*\*\***

Liv/GB(wood) Ht/SI (Fire) Sp/ST (Earth)

irritability/anger heart palpitations heaviness anywhere in body

depression/stress chest pain fatigue/worse after eating

headaches/migraines insomnia/sleep problems hard to get up in morning

visual problems easily startled edema (swelling)

red/dry/itchy eyes restlessness/agitation muscles feel tired often

gall stones vivid dreams easily bruising and bleeding

dizziness lack of joy in life bad breath

blurred vision dry scalp decreased/increased appetite

feeling of lump in throat skin rash crave sweets

clenching of teeth at night cysts/tumor hypoglycemia

muscle cramping/twitching ear infection difficulty digesting oily foods

tension sore throat nausea/vomiting

joints/neck/shoulder pain lymph swelling gas/belching

poor circulation hot palms/soles insulin sensitivity

soft/brittle nails aversion to heat hemorrhoids

emotional eater bitter taste in mouth constipation

ringing in ears gum problems diarrhea

eczema nose bleed abdominal pain

Shingles facial redness indigestion/heartburn

herpes simplex itchy/burning skin over-thinking

indecisive thirst tendency to gain weight

fullness below ribs dark blue brain foggy

shoulder/neck tension night sweats food allergy

insomnia 11pm-3am excess joy excess worry

Lu/LI (Metal) Kid/UB (Water) OTHER

dry cough urinary problems fatigue

cough with sputum bladder problems arthritis

nasal discharge lack of bladder control sciatica

post-nasal drip weakness/pain in lower back nerve pain

sinus trouble decreased bone density carpal tunnel

itchy/red/painful feel cold easily numbness

dry mouth/throat/nose low sex drive cold hands/feet

skin rashes/hives excess sexual drive bursitis/tendonitis

snoring poor memory

grief/sadness loss of hair

shortness of breath hearing problems

asthma/allergies cavities/tooth loss

low resistance to colds or flu craving/avoiding salty foods

sneezing fear

mild fever comes and goes hot flash/night sweating

smoke cigarettes dark under eyes

bronchitis

weak leg/knees

rapid weight change

emotional instability

thyroid problems

## Medications/Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them.

| Medications | Reasons | Date Began | Dose | Helps  Yes or No |
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| Supplements | Reason | Date Began | Dose | Helps  Yes or No |
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## Please describe any other health concerns not previously covered in this form.



*Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.*

Signature Date

# Westtown WellnessA picture containing text, clipart Description automatically generated

# Jessica Briecke L.M.T., N.C.

# Informed Consent to Treat

## FORM MUST BE SIGNED BY ALL PARTICIPANTS. IF PARTICIPANT IS UNDER 18 YEARS OF AGE, FORM MUST BE SIGNED BY MINOR AND HIS/HER PARENT/GUARDIAN.

I hereby request and consent to the performance of massage therapy, plasma fibroblast, or nutritional consultation treatments and other procedures within the scope of practice of massage therapy, plasma fibroblast or nutritional consultation (or on the patient named below, for whom I am legally responsible) by Jessica J Briecke and/or other licensed practitioners who now or in the future treat me while employed by, working or associated with Westtown Wellness.

I understand that methods of treatment may include, but are not limited to massage therapy, stretching, application of heat therapy, plasma fibroblast treatment, application of topical anesthetic, infrared sauna, LED light therapy, supplement suggestions and nutritional counseling. I understand that the supplements may cause potential unwanted side effects and I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the suggested supplements.

I have been informed that massage therapy, plasma fibroblast, infrared sauna, LED light therapy, and whole food supplementation is a generally safe method of treatment, but that it may have some side effects including bruising, muscle discomfort, light headedness, fatigue, carbon dots on the skin. Burns and /or scarring are a potential risk of plasma fibroblast. Bruising is a possible side effect of massage therapy.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of whole food eating and wellness plan, although some may be toxic in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy. Some possible side effects of taking herbs and supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Participant:

Signature of Participant: Date:

## MINOR INFORMATION:

Name of Parent/Legal Guardian: Age (If A Minor)

Signature of Parent/Legal Guardian: Date: