Confidential Client Health Intake Form

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All answers are confidential.

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____ Email: _____

Is it OK to leave a message about your care at the phone number and email listed above? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: _____ Occupation: _____

Name of Primary Care Physician: _____ Phone: _____

Are you Pregnant? _____ Do you have a pacemaker? _____ Have you ever had chemo? _____

How did you hear about this practice? _____

Integrative medicine is a patient-focused, whole-person medical practice that uses a variety of disciplines including alternative and conventional Western medical therapies to provide safe, effective health care. How comfortable are you with integrative medicine (on a scale of 1-10)? _____

Please share all issues and/or heath concerns for which you are seeking care. Include dates of when symptoms first appeared and any diagnoses you have received. Provide as much detail as possible.

_____

_____

_____

_____

_____

_____

_____

What makes your conditions better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

_____

What makes your conditions worse? (Stress, fatigue, environment, certain foods, repetitive motion, etc.)

_____

Are you experiencing pain? If yes, where? Rate your pain on a scale of 1-10: _____

_____

Are you experiencing anxiety/stress? Rate your anxiety/stress on a scale of 1-10: _____

Do you consume alcoholic beverages? If yes, how much per week? _____

Do you smoke tobacco, marijuana or vape? If yes, which and how much per week? _____

Do you have dentures or partials? If yes, which and where: _____

Have you ever had a dental infection, root canal or wisdom/other tooth pulled? If so, which condition and which tooth (teeth)?

_____

How many hours of sleep do you get per night? _____

Do you have trouble falling asleep? _____ Do you have trouble staying asleep? _____

Have you ever been exposed to mold? If yes, please describe: _____

Have you ever had a concussion or hit your head? If yes, please describe: _____

Have you had any surgeries? If so, please describe: _____

Please describe your diet: _____

Do you eat dairy? _____ Wheat/Gluten? _____ Fish/Sushi? _____

Do you crave sugar? _____ Do you consume soda/energy drinks? If so, how often? _____

Does your stomach hurt or get bloated after eating? _____ Do you have a daily bowel movement? _____

Do you exercise? If yes, what types of exercise and how often? _____

What vaccines did you receive as a child? _____

To your knowledge, did you have any adverse reactions? _____

What vaccines have you had recently? _____

Did you have any adverse reactions? _____

List ALL prescriptions and over the counter medications you are currently taking:

_____

_____

_____

List ALL vitamins and herbal supplements you are currently taking:

_____

_____

Did you have any major childhood illnesses? Please list illness(es) and age(s):

_____

It is widely accepted that there is no manifestation of a symptom or disease without an emotional root. These emotions are held in the subconscious mind, and often we are unaware of them. The following questions are meant to help bring all emotional trauma, whether big or small, recent or past, to the conscious mind so it too can be addressed through Biomagnetism. They are not meant bring about a discussion or offer a service that would take the place of being seen by a licensed therapist.

Are you currently or have you in the past participated in counseling? Do you feel it helped?

_____

Do you have memories of trauma or significant loss as a child? Please describe and include age(s):

_____

Have you been told of a traumatic experience(s) as a child but have no memory of them? Please list:

_____

_____

Have you had significant trauma or loss as an adult? Please describe and include age(s):

_____

_____

Have you experienced emotional/physical/sexual abuse as a child or an adult?

_____

What other forms of alternative therapies/treatments are you **currently** receiving?

_____

_____

What other forms of alternative therapies/treatments have you received in the **past**?

_____

Do you feel these alternative therapies/treatments are helping or have helped in the past?

_____

Do you have any other information you would like to share?

_____

_____

_____

_____

_____

_____