CLIENT INTAKE

All client information/data is confidential and honors HIPAA Privacy Rules. This intake form, in its totality, provides Motif and Client with foundation information to assess and together create an integrated health and wellness course of action that compliments Client's medical team (if applicable).

HIPAA COMPLIANT

- PAGES **3** & **4** ARE TO BE DUPLICATED AND COMPLETED FOR EACH CONCERN/ISSUE
- INTAKE INCLUDES AYURVEDA QUIZZ
- SOME ASSESSMENTS ARE IN-PERSON
- TOUCH/MANUAL THERAPY IS APPLIED IN YOMASSAGE CLASSES, AYURVEDA TREATMENTS, YOGA ADJUSTMENTS AND DEEPENING POSTURES, AND PERSONAL TRAINING SESSIONS

about you!

Full Legal Name _____

Preferred Name _____

Cis Gender & Identify As _____

MOTIF HONORS ALL GENDERS, IDENTITIES, PRONOUNS, SHAPES, SIZES, AND ETHNICITIES THOUGH INTAKE AND ADDITIONAL MATERIALS INCLUDE DEPICTIONS OF TRADITIONAL MALE AND FEMALE FORMS.

Address _____

Date of Birth _____

Cultural Background & Ethnicity: as granular as possible if known

_____

_____

_____

Contact Information: mobile, email, & note preference

_____

Emergency Contact Name, Mobile, & Relationship to Client:

_____

_____

Medical Bracelete Conditions & Allergies:

_____

_____

let's prioritize

DESCRIBE YOUR PRESENT HEALTH CONDITIONS CONCERNING DISCOMFORT AS CONCISE AS POSSIBLE IDENTIFY ISSUES WITH A DESCRIPTIVE TITLE, EXAMPLES: TIGHT LOW BACK PAIN, DEPRESSION, CHRONIC FATIGUE SYNDROME, ARTHRITIS IN BOTH HANDS, COLON CANCER, ETC. DUPLICATE THIS PAGE TO ADD ADDITIONAL ISSUES ACCORDING TO PRIORITY, DEGREE OF SYMPTOMS, PAIN, DIAGNOSIS, PROGNOSIS, ETC. AND NUMBER THEM IN SAID ORDER. YOU WILL REFER TO EACH NUMBERED CONCERN ON FOLLOWING PAGES.

Concern/Priority # 1, 2, 3, or 4 _____

Date of Onset: _____

Does this issue run in the family? _____

About Concern:

_____

_____

_____

_____

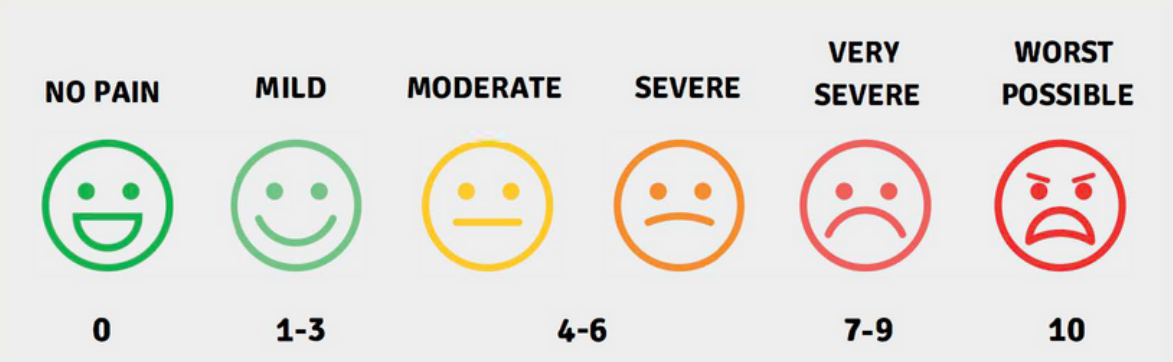
Current Status --> select all that apply

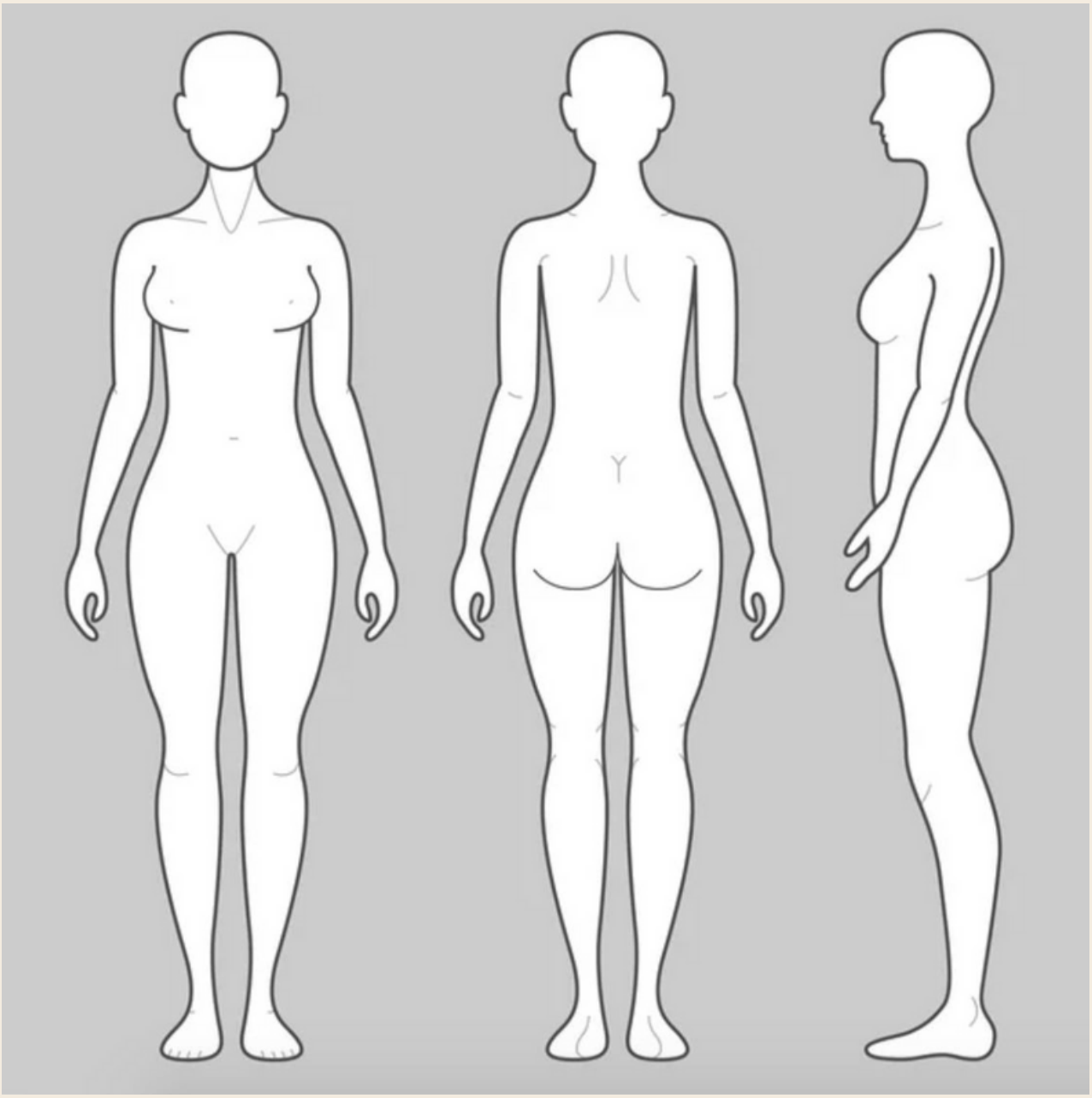
- ◯ accute stage and/or flareup
- ◯ chronic condition
- ◯ intermittenet pain
- ◯ chronic pain
- ◯ condition worsening
- ◯ progressive condition
- ◯ controlled/stable
- ◯ remission
- ◯ sharp pain
- ◯ pinpointed pain
- ◯ diffuse pain

Are you currently (or previously) under the care of a medical and or other health and wellness professional for this particular concern? Is/was there a high-level plan of action approach towards this health issue/condition and has there been progress? List specific medications addressing this issue including OTC. Please duplicate this page for each concern.

CONCERN/PRIORITY #?

MARK PINPOINTED LOCATIONS OF **PAIN/DISCOMFORT**, **DISEASE, ETC.** USING THE ASSOCIATED NUMBER FROM PREVIOUS SECTION TITLED CONCERNS. INSERT USING SHAPE OR DRAW FUNCTION TO INDICATE LARGER AREAS AFFECTED THEN ADD THE RELEVANT CONCERN NUMBER ASSOCIATED TO THE PREVIOUS PAGES, AND INDICATE PAIN LEVEL ACCORDING TO THE BELOW CHART.





HIGH-LEVEL MEDICAL

SELECT ALL THAT APPLY

- ◯ HAVE YOU HAD GOUT?
- ◯ ARE YOU DIABETIC?
- ◯ HISTORY OF DVT?
- ◯ DO YOU HAVE ANY IMPLANTS?
- ◯ DO YOU HAVE MS?
- ◯ SPINAL DISORDER?
- ◯ INVASIVE PROCEDURES?
- ◯ MEDICAL DIAGNOSIS?
- ◯ MENTAL HEALTH DIAGNOSIS?
- ◯ ARE YOU PREGNANT?
- ◯ DO YOU SMOKE/VAPE?
- ◯ CHILDBIRTH?
- ◯ NEW TO MASSAGE THERAPY?
- ◯ NEW TO AYURVEDA?
- ◯ DO YOU HAVE AN ENDOCRINOLOGIST?
- ◯ SENSITIVE TO TEMPERATURE?
- ◯ SENSITIVE TO SCENTS?
- ◯ SENSITIVE TO TOUCH?
- ◯ SENSITIVE TO SOUND?
- ◯ BOWEL MOVEMENTS 1-3 X DAILY?
- ◯ MOUTH DISEASE OR ISSUES?
- ◯ SENSITIVE SKIN?

TYPICAL WEEKLY EXERCISE & MOVEMENT

- ◯ INTENSE
- ◯ HOBBY
- ◯ STRETCHING
- ◯ LOW
- ◯ NOTHING
- ◯ MEDIUM

SELECT ALL THAT APPLY

TYPICAL HOURS OF SLEEP

hours

1 2 3 4 5 6 7 8

DAILY WATER INTAKE

cups

1 2 3 4 5 6 7 8

THINGS THAT MAKE YOU HAPPY

1.
2.
3.
4.
5.

GENERAL MOOD

ANGRY TIRED SAD GREAT FUN

How is your sleep?

☐ Sound, normal duration ☐ Light, interrupted ☐ Too little sleep

☐ Too heavy and/ or too long ☐ Difficulty falling asleep ☐ Difficulty waking up

☐ Awaken too early ☐ Frequently nightmares

What is your sleep position?

☐ Left Side ☐ Right Side ☐ On back ☐ On tummy ☐ Other _____

How regular is your daily routine? (For example, do you go to bed early, eat your meals on time, exercise reg.?)

☐ Very Regular ☐ Somewhat Regular ☐ Irregular

Describe your bowel movements:

☐ Once every 2-3 days ☐ Once daily ☐ 2-3 times per day

☐ First thing in the morning ☐ Late in daytime ☐ Immediately after meals

☐ Immediately after dinner ☐ Need laxative daily ☐ Other _____

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Bowel Movement associated with:

☐ Pain ☐ Gas ☐ Blood ☐ Mucus ☐ Foul Smell ☐ Other

Do you delay or suppress any of the following?

☐ Sleep ☐ Bowel movements ☐ Gas ☐ Urination ☐ Yawning ☐ Burping

☐ Thirst ☐ Breathing ☐ Semen ☐ Hunger ☐ Sneezing ☐ Crying, Tears

Do you travel a lot? ☐ Yes ☐ No

Do you oil massage daily ☐ Yes ☐ No

What taste(s) do you like or crave?

☐ Sweet ☐ Salty ☐ Sour ☐ Bitter ☐ Hot / Spicy ☐ Starchy ☐ Oily

Are there particular foods that create discomfort when you eat them?

☐ Sweet ☐ Salty ☐ Sour ☐ Bitter ☐ Astringent ☐ Dairy Products (including cheese)

Do you practice any type of meditation? Please explain

Do you practice yoga? Please explain.

Which type of weather makes you feel most uncomfortable?

☐ Cold ☐ Hot ☐ Cool & Damp

Are you allergic to any substances?

☐ Food ☐ Pollen ☐ Dust ☐ **Medication** **Other?**

Do you smoke cigarettes (or other substances)? ☐ Yes ☐ No

If yes, how many per day? ☐ 1/2 pack ☐ 1 pack ☐ 2 packs ☐ More than 2 packs

How often do you drink alcohol?

☐ Never ☐ Less than once a week ☐ About once a week ☐ Several times a week

☐ Once a day ☐ More than once a day ☐ How much at a time? _____

NUTRITION

Do you eat between meals? ☐ Yes ☐ No

Do you eat your meals at regular times? ☐ Yes ☐ No

Which is your biggest meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion ☐ Good ☐ Fair ☐ Bad

How much water do you drink per day? ☐ None ☐ 1-2 Glasses ☐ 3-4 Glasses ☐ 5-6 Glasses ☐ 7+ Glasses

Indicate your eating habits ☐ Eat with my full attention on food ☐ Eat very quickly ☐ Converse a lot while eating ☐ Rarely sit down to eat ☐ Watch television while eating

Describe your diet ☐ Vegan ☐ Lacto-vegetarian ☐ Lacto-ovo vegetarian ☐ Other _____

If you are a nonvegetarian, please indicate the proteins you eat.

☐ Beef ☐ Pork ☐ Chicken ☐ Turkey ☐ Seafood ☐ Eggs ☐ Other _____

Indicate which best describes your sense of taste (if any).

☐ Loss of taste ☐ Sweet taste in mouth ☐ Sour taste in mouth ☐ Pungent taste in mouth ☐ Bitter taste in mouth

SOCIAL & EMOTIONAL

How often do you drink caffeinated beverages?

☐ Never ☐ 1 cup daily ☐ 2–3 cups daily ☐ 4–5 cups daily

How would you rate your usual energy level?

☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very Low

Do you experience any of the following?

☐ Depression ☐ Anxiety ☐ Fear or panic ☐ Loneliness ☐ Worry

☐ High stress level ☐ Anger ☐ Lack of memory ☐ Light-headedness ☐ Lack of energy

☐ Suicidal thoughts or attempts ☐ Irritation

How are your family relationships? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your mental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ It's bearable ☐ It's unbearable

How purposeful does your life feel? ☐ Completely ☐ Somewhat ☐ Neutral ☐ Purposeless

Rate your spiritual life.

☐ Fully satisfying ☐ Somewhat satisfying ☐ Neutral ☐ Empty

T R A U M A

ADDRESSING TRAUMA IS NOT LINEAR, EVEN IF A SINGLE EVENT
SOME OF THE QUESTIONS ON THE PREVIOUS PAGE MIGHT VERY WELL BE SIGNS, SYMPTOMS,
AND EFFECTS/RESULTS OF TRAUMA. PLEASE ELABORATE, IF POSSIBLE, WITH WHICH ARE TRAUMA-RELATED.

MOTIF SERVICES INCLUDE TOUCH/MANUAL THERAPY INTO YOGMASSAGE CLASSES, AYURVEDA TREATMENTS, MASSAGE THERAPY, YOGA DEEPENING AND ADJUSTMENTS, AND PERSONAL TRAINING SESSIONS.

MOTIF IS COMMITTED TO PROVIDING A SAFE SPACE, TAKING CLIENT TRAUMA INTO CONSIDERATION.

PLEASE USE THE FOLLOWING PAGE TO SHARE YOUR NEEDS.

T R A U M A

Elaborate on selections made on page 6, if applicable, even if it also intersects with the trauma-related input. Be as thorough as possible. Duplicate page if needed.

HOSTPIALIZATIONS

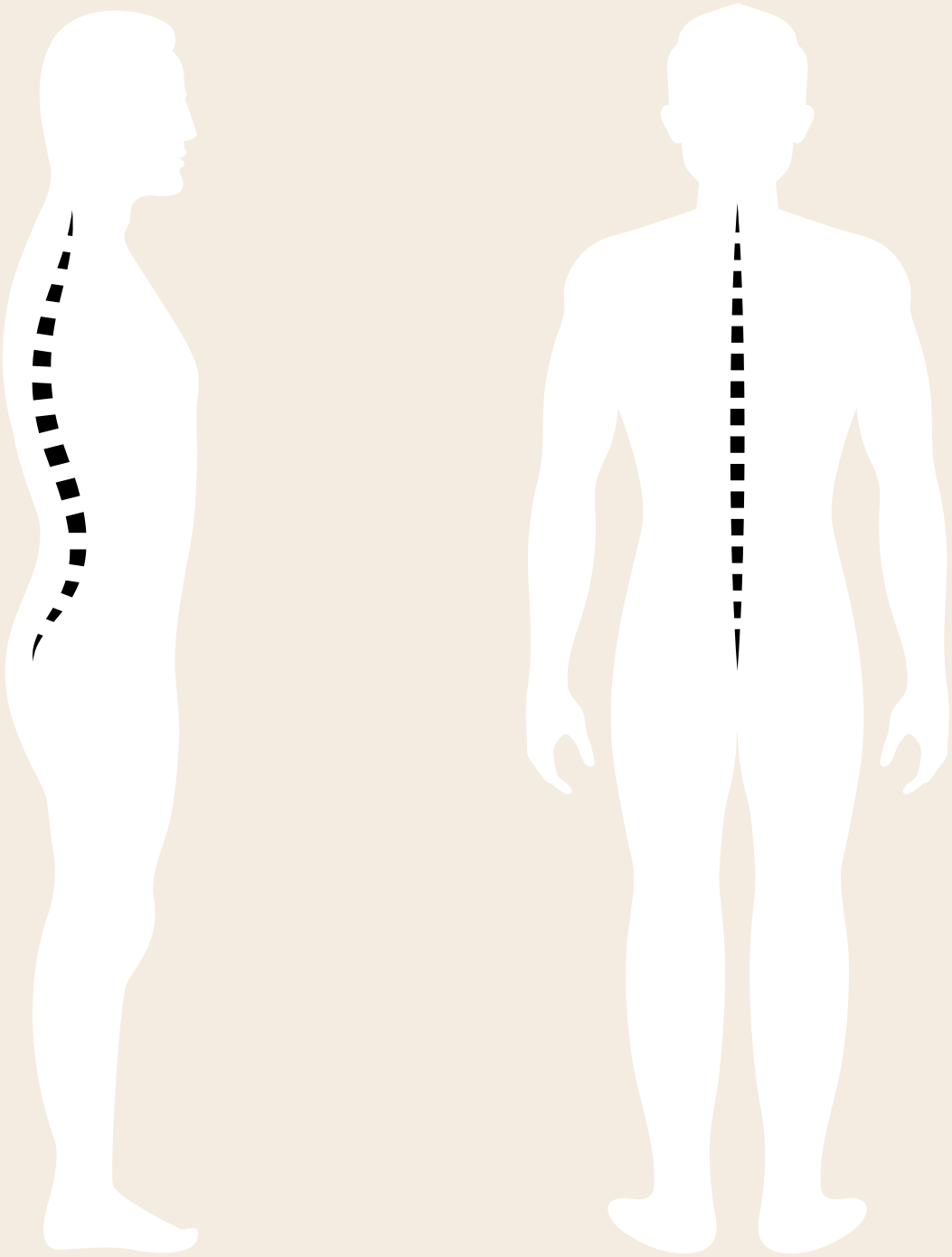
CONCERN #	YEAR	PROCEDURE

GENETICS

Condition	MOTHER	FATHER	SIBLING/S	PGF	PGM	MGF	MGM
Diabities							
High Blood Pressure							
Low Blood Pressure							
Hyperthyroid							
Hypothyroid							
Cancer							
Parkinsins							
Multiple Sclerosis							
Deep Vein Thrombosis							
Heart Disease							
Osteoarthritis							
Rheumatoid Arthritis							
Depression							
Anxiety							
Stroke							
Other (list below)							

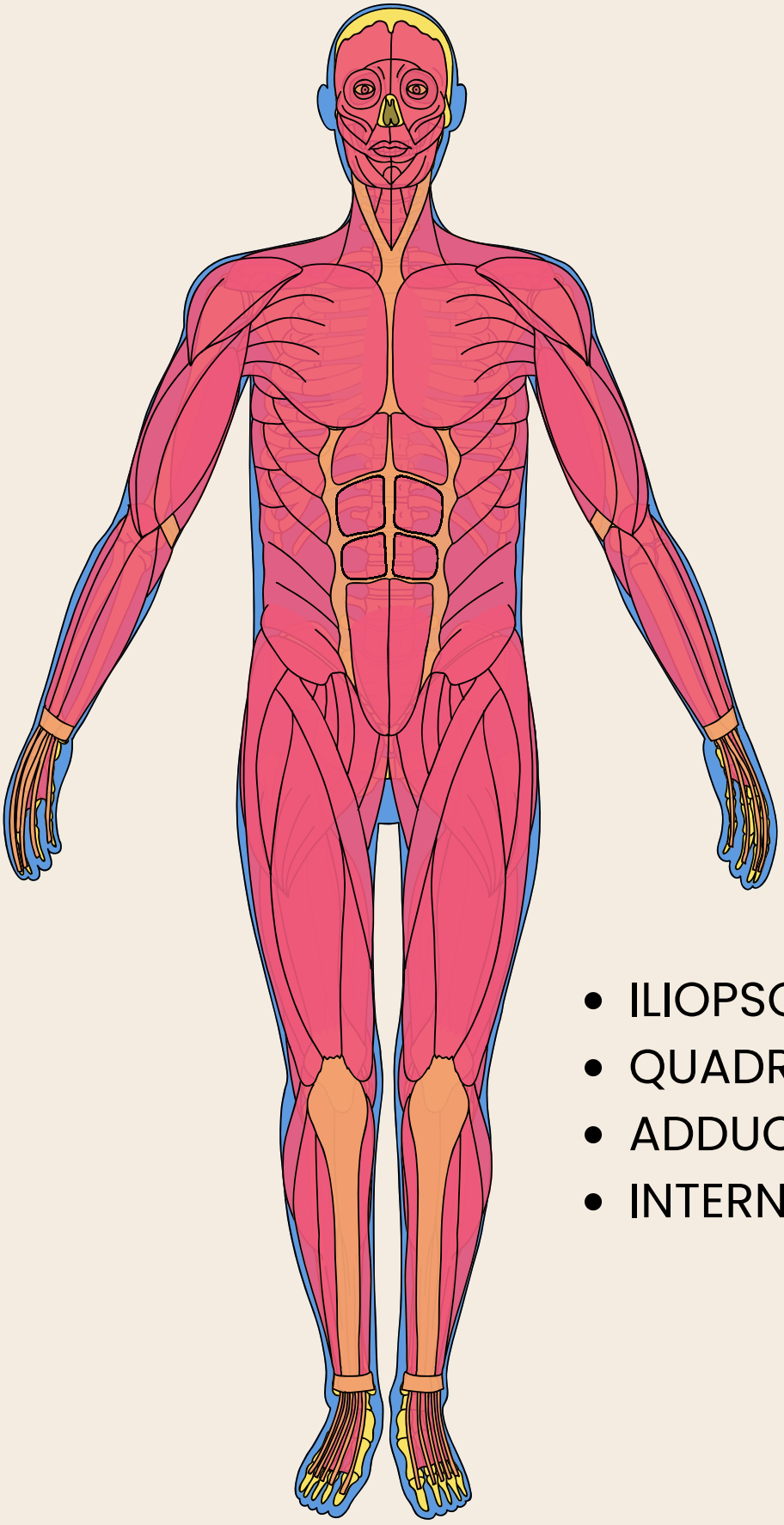
A L I G N M E N T / P O S T U R E

IN-PERSON ASSESSMENT



SPECIAL TESTS

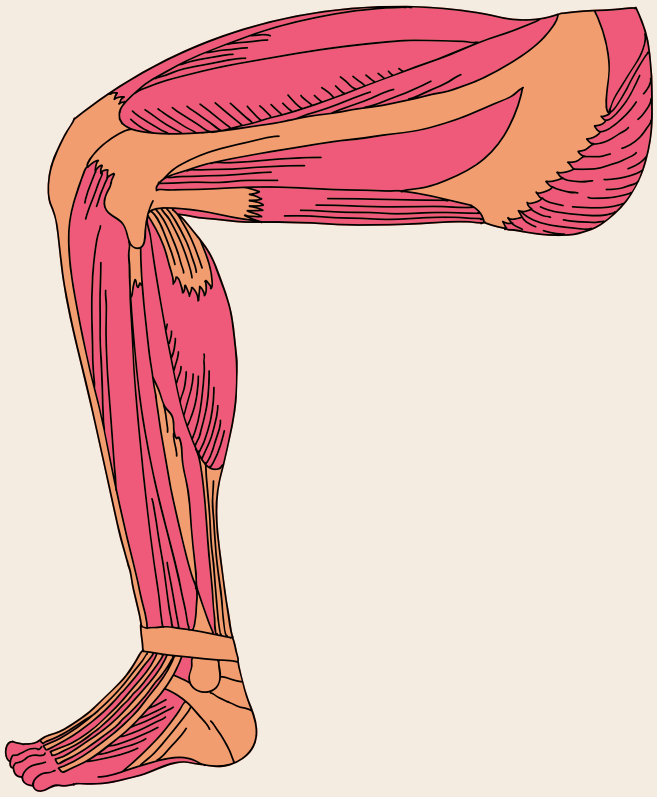
IN-PERSON ASSESSMENT

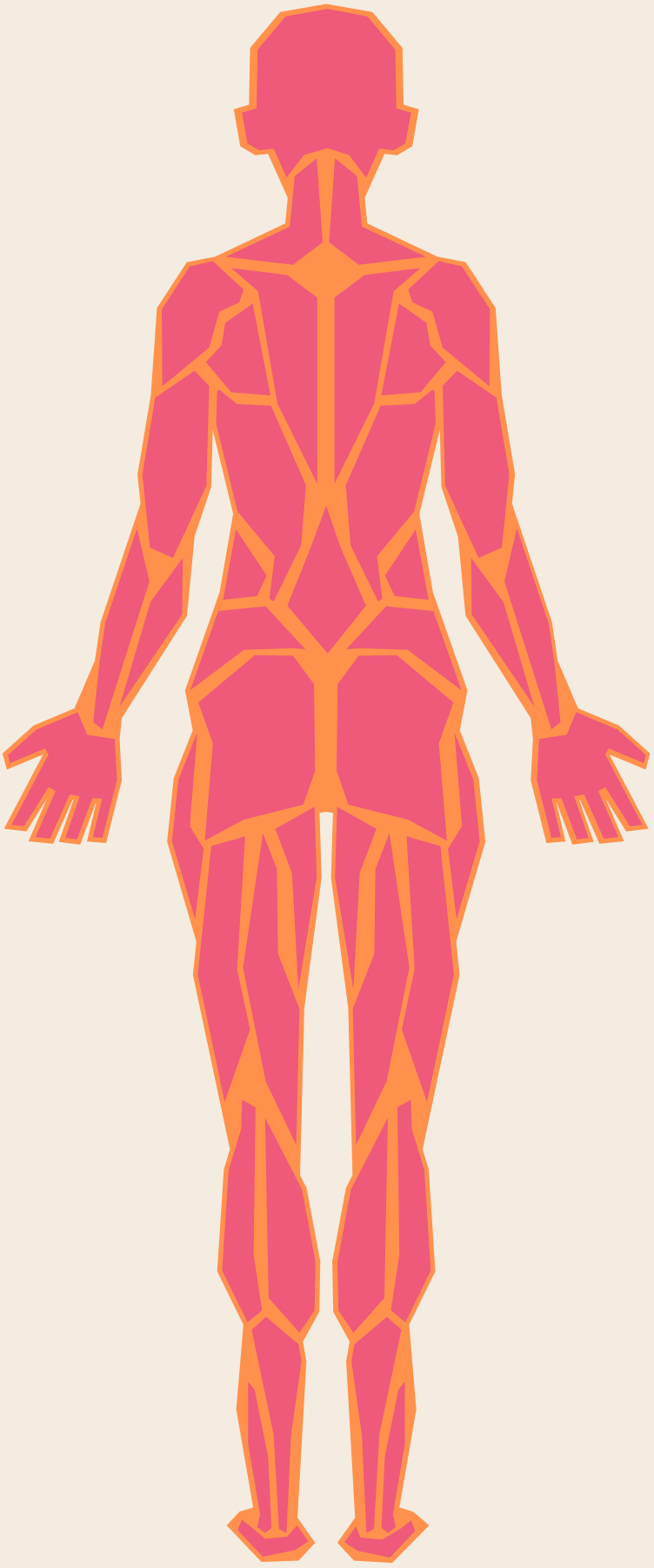


- ILIOPSOAS
- QUADRICEPS
- ADDUCTORS
- INTERNAL ROTATORS

SPECIAL TESTS

IN-PERSON ASSESSMENT





- GLUTEUS MAXIMUS
- HAMSTRINGS
- ABDUCTORS
- EXTERNAL ROTATORS

Dosha Quiz

Mark the description that suits you as number 1 (one), when you are in a rested state and are functioning well.

CHARACTERISTICS	VATA	PITTA	KAPHA
BODY SIZE	( ) SLIM	( ) MEDIUM	( ) LARGE
BODY WEIGHT	( ) LOW	( ) MEDIUM	( ) HEAVY
SKIN	( ) THIN, DRY, COLD, ROUGH, DARK	( ) SMOOTH, OILY, WARM ROSY	( ) THICK, OILY, COOL, WHITE, PALE
HAIR	( ) DRY BROWN, BLACK, KNOTTED, BRITTLE, THINK	( ) STRAIGHT, OILY, BLONDE, GREY, RED, BALD	( ) THICK, CURLY, OILY, WAVY, LUXURIANT, ALL COLORS
TEETH	( ) PROTRUDING, BIG, ROOMY, THIN GUMS	( ) MEDIUM, SOFT, TENDER GUMS	( ) HEALTHY, WHITE, STRONG GUMS
NOSE	( ) UNEVEN SHAPE, DEVIATED SEPTUM	( ) LONG POINTED, RED NOSE-TIP	( ) SHORT ROUNDED, BUTTON NOSE
EYES	( ) SMALL, SUNKEN, DRY, ACTIVE, BLACK, BROWN, NERVOUS	( ) SHARP, BRIGHT, GREY, GREEN, YELLOW/RED, SENSITIVE TO LIGHT	( ) BIG, BEAUTIFUL, BLUE, CALM, LOVING
NAILS	( ) DRY, ROUGH, BRITTLE, BREAK EASILY	( ) SHARP, FELXIBLE, PINK, LUSTROUS	( ) THICK, OILY, SMOOTH, POLISHED
LIPS	( ) DRY, CRACKED, BLACK/BROWN TINGED	( ) RED INFLAMED, YELLOWISH	( ) SMOOTH, OILY, PALE, WHITISH
CHIN	( ) THIN, ANGULAR	( ) TAPERING	( ) ROUNDED, DOUBLE

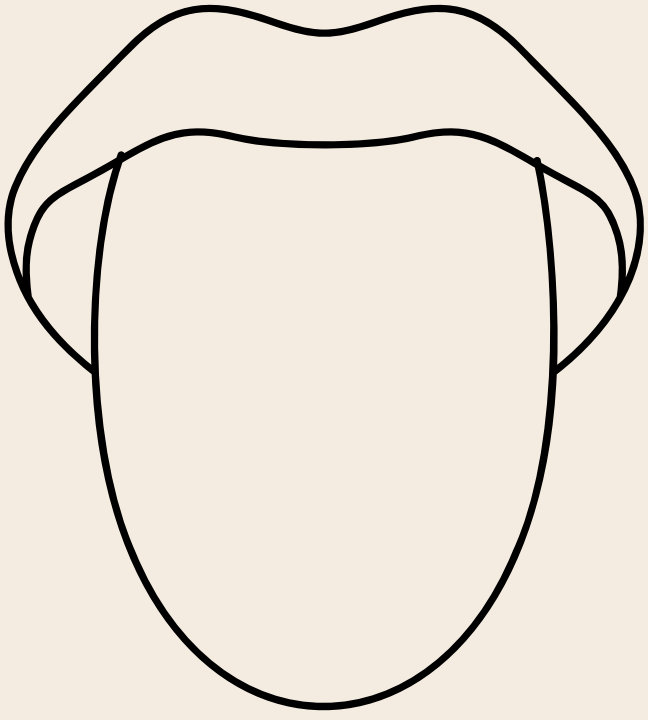
CHARACTERISTICS	VATA	PITTA	KAPHA
CHEECKS	( ) WRINKLED, SUNKEN	( ) SMOOTH, FLAT	( ) ROUNDED, PLUMP
NECK	( ) THIN, TALL	( ) MEDIUM	( ) BIG, FOLDED
CHEST	( ) FLAT, SUNKEN	( ) MODERATE	( ) EXPANDED, ROUND
BELLY	( ) THIN, FLAT, SUNKEN	( ) MODERATE	( ) BIG, POTBELLIED
BELLY BUTTON	( ) SMALL, IRREGULAR, HERNIATED	( ) OVAL, SUPERFICIAL	( ) BIG, DEEP, ROUND, STRETCHED
HIPS	( ) SLENDER, THIN	( ) MODERATE	( ) HEAVY, BIG
JOINTS	( ) COLD, CRACKING	( ) MODERATE	( ) LARGE, LUBRICATED
APPETITE	( ) IRREGULAR, SCANTY	( ) STRONG, UNBEARABLE	( ) SLOW BUT STEADY
DIGESTION	( ) IRREGULAR, FORMS GAS	( ) QUICK, CAUSES BURNING	( ) PROLONGED, FORMS MUCUS
TASTE, HEALTHY PREFERENCE	( ) SWEET, SOUR, SALTY	( ) SWEET, BITTER, ASTRINGENT	( ) BITTER, PUNGENT, ASTRINGENT

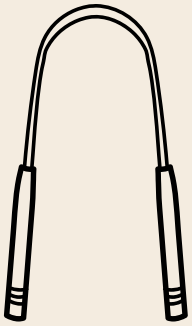
CHARACTERISTICS	VATA	PITTA	KAPHA
SPEECH	( ) RAPID, UNCLEAR	) SHARP PENETRATING	( ) SLOW, MONOTONOUS
THIRST	( ) CHANGEABLE	( ) SURPLUS	( ) SPARSE
ELIMINATION	( ) CONSTIPATION	( ) LOOSE	( ) THICK, OILY, SLUGGISH
PHYSICAL ACTIVITY	( ) HYPERACTIVE	( ) MODERATE	( ) SEDENTRY
MENTAL ACTIVITY	( ) ALWAYS ACTIVE	( ) MODERATE	( ) DULL, SLOW
EMOTIONS	( ) ANXIETY, FEAR, UNCERTAINTY, FLEXIBLE	( ) ANGER, HATE, JEALOUSY, DETERMINED	( ) CALM, GREEDY, ATTACHMENT
EMOTIONS FAITH	( ) VARIABLE, CHANGEABLE	( ) INTENSE, EXTREMIST	( ) CONSISTENT, DEEP, MELLOW
INTELLECT	( ) QUICK BUT FAULTY RESPONSE	( ) ACCURATE RESPONSE	( ) SLOW, EXACT
RECOLLECTION	( ) RECENT GOOD, REMOTE POOR	( ) DISTINCT	( ) SLOW AND SUSTAINED
DREAMS	( ) QUICK, ACTIVE, MANY, FEARFUL	( ) FIERY, WAR, VIOLENCE	( ) LAKES, SNOW, ROMANTIC
SLEEP	( ) SCANTY, BROKEN UP, SLEEPLESSNESS	( ) LITTLE BUT SOUND	( ) DEEP, PROLONGED
FINANCIAL	( ) POOR, SPENDS ON TRIFLES	( ) SPENDS MONEY ON LUXURIES	( ) RICH, GOOD MONEY PRESERVER

Total of each column			

F A C E & T O U N G E

IN-PERSON ASSESSMENT





M O V E M E N T

For this intake, movement is categorized in three intensities: **low, medium,** and **high** involvement. For example, ...

- low is taking a leisure walk up to three miles golf, etc.
- medium is thorough house cleaning, gentle yoga, brisk walking up to three miles, dancing, martial arts, light weightlifting, baseball,etc.
- high is running, sprinting, powerful sports, exercise dance, overload weightlifting, vinyasa yoga, intense landscaping and yard work/chopping wood, hiking inclines, etc.

-Duplicate page if need more than four movement inputs-

1.Movement:
a.Type of Movement: low, medium, or high involvement
b.Frequency per week/month
c. Duration

2.Movement:
a.Type of Movement: low, medium, or high involvement
b.Frequency per week/month
c.Duration

3.Movement:
a.Type of Movement: low, medium, or high involvement
b.Frequency per week/month
c.Duration

4. Movement:
a.Type of Movement: low, medium, or high involvement
b.Frequency per week/month
c.Duration

CIS GENDER CONCERNS

GLOBALLY, WE ARE RETHINKING THE CONCEPT OF GENDER TO A MUCH MORE INCLUSIVE DEFINITION. SEPARATELY, AS PRACTITIONERS, MASSAGE THERAPISTS, PHYSICAL THERAPIST, MEDICAL PROFESSIONS, ETC., KNOWING ONE'S CIS GENDER IS CRITICAL TO UNDERSTANDING CLIENT'S BORN PHYSIOLOGICAL MAKEUP AND HOW CIG-GENDER COMPLICATIONS ARE CONTRIBUTING TO AN IMBALANCE IN HOMEOSTASIS.

Do you experience any of the following?

☐ Hernias ☐ Sexual difficulty ☐ Urination ☐ Erection problem ☐ Libido

☐ Birth control ☐ Prostate problems ☐ Discharge or sores ☐ Venereal disease ☐ Testicular masses

Age menses began: _____.

Which of the following describes your menstruation?

☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

Which of the following describes your menstruation?

☐ 1–4 days ☐ 5–7 days ☐ More than 1 week ☐ Irregular throughout the month

☐ Other _____.

How is your menstrual flow?

☐ Normal ☐ Heavy ☐ Light ☐ Abnormal vaginal discharge

Do you have any associated symptoms (before or during menstruation)?

☐ None ☐ Pain ☐ Fluid retention ☐ Migraine ☐ Depression

☐ Acne ☐ Tension ☐ Nightmares ☐ Frustration ☐ Loneliness

DO YOU HAVE ANY DISCHARGE OUTSIDE OF YOUR MENSTRUAL PERIOD?

DO YOU EVER EXPERIENCE PAIN DURING INTERCOURSE?

DO YOU HAVE ANY SEXUAL DIFFICULTIES?

DO YOU TAKE CONTRACEPTIVE PILLS OR USE OTHER FORMS OF BIRTH CONTROL?

NUMBER OF PREVIOUS PREGNANCIES

DO YOU HAVE A HISTORY OF ABORTION, MISCARRIAGE, OR PROBLEMS RELATED TO PREGNANCY OR

LABOR?

HOW OLD ARE YOUR CHILDREN?

DO YOU DO A BREAST SELF-EXAM REGULARLY?

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

PAIN
TENDERNESS
LUMPS
NIPPLE DISCHARGE

STATEMENT OF UNDERSTANDING

- I UNDERSTAND THAT MOTIF IN MOVEMENT (ALSO RENDERED AND REFERRED TO AS MOTIF STUDIO & SPA) DOES NOT PROVIDE MEDICAL DIAGNOSES OR TREATMENT, AND THAT MOTIF REPRESENTATIVES AND EMPLOYEES ARE NOT DOCTORS.

- I UNDERSTAND THAT MOTIF SERVICES (INCLUDING BUT NOT LIMITED TO AYURVEDA, MASSAGE THERAPY, AND PERSONAL TRAINING PROGRAMS) ARE NOT SUBSTITUTES FOR PROFESSIONAL MEDICAL CARE.

- I UNDERSTAND THAT MOTIF AYURVEDA TREATMENTS ARE NOT MEDICAL TREATMENTS, AND THAT THE WORD “TREATMENT” FROM THE INTEGRATED HEALTH AND WELLNESS PERSPECTIVE POINTS TO THE MEANS/APPROACH TO ADDRESSING IMBALANCES TO OBTAIN OVERALL HOMEOSTASIS.

- I UNDERSTAND THAT MOTIF RECOMMENDS AYURVEDA CLIENTS TO VISIT AN AYURVEDIC DOCTOR AT LEAST ONCE A YEAR, IF POSSIBLE.

- I UNDERSTAND THAT I MUST INFORM MOTIF PRIOR TO A SESSION OF ANY CHANGES IN MY STATUS.

- I UNDERSTAND THAT THERE ARE NO REFUNDS FOR MOTIF SERVICES.

- I UNDERSTAND THAT IF I CANCEL AN APPOINTMENT LESS THAN 48 HOURS BEFOREHAND, THAT THE CLIENT FORFEITS THE COST OF THAT SESSION. SIMILARLY, I UNDERSTAND THAT IF MOTIF CANCELS AN APPOINTMENT LESS THAN 48 HOURS BEFOREHAND, THAT MOTIF NOT ONLY REFUNDS THAT SESSION BUT ALSO PROVIDES A COMPLEMENTARY SESSION.

- I UNDERSTAND THAT BY SIGNING AND DATING BELOW, I AGREE TO ALL ABOVE TERMS.

CLIENT PRINTED NAME

_____

CLIENT SIGNATURE AND DATE

_____

PRACTITIONER PRINTED NAME

_____

MOTIF IN MOVEMENT (OWNER) AND DATE

_____