**Uniq Creations** - a Holistic Wellness Practice

**Intake / Client Consent Form:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province:\_\_\_\_\_\_\_\_\_\_\_\_\_ PC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday(dd/mm/yy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:(w)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Phone of referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your purpose for incorporating holistic wellness?

Do you have pain or discomfort? Where?

When did it start? How long have you had it? Does it come and go?

Does anything make it worse? (E.g. sitting, standing, bending etc)

Does anything make it better? (Moving around, ice, pain killers, hot water bottle, rest, essential oils etc)

**Exercise / Movement Habits:**

What are your exercise or movement habits? Frequency? Time of day?

Would you be interested in Somatics? – slow, voluntary movements connecting brain & muscle memory to support releasing chronic symptoms!

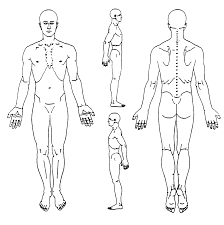
Have you had any accidents, injuries, or trauma in the past 2-5 years?

**Stress:**

What level of stress do you experience regularly (1-10)?

Do you experience times of anxiety, depression or have ongoing fear?

Any associated problems with the pain? (e.g. sciatica or numbness/tingling in buttock, toes, fingers etc)



**Sleep Concerns / Habits:**

Are you able to get to Sleep? Stay asleep? Get back to sleep?

What time does it keep you awake at night?

Circle the quality of your sleep? (1-poor / 2-average / 3-pretty good / 4-great )

Are you aware Thai Massage, Craniosacral Therapy, Aromatherapy & Somatics all support better sleep habits?

**Posture +:**

What is your level of general conscious body awareness? 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

Are you aware of your breathing pattern?  Chest / Abdomen / long, smooth / short, sticky?

Mouth or Nostril breathing?

What is your posture awareness for the below options? (1-poor; 2-average; 3-pretty good; 4-great)

Lying Down- Seated- Standing- In Motion-

**Health History:**

Are you currently taking any medications? Please list main vitamins, minerals, herbal or homeopathic remedies you are currently taking.

Do you have any allergies or sensitivities?

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, understood and completed, to the best of my knowledge, the Intake / Client Consent form. I release Uniq Creations from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history form.

May we contact you via: phone or text or email

Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_