New Client Intake Form

CONTACT INFORMATION TODAY'S DATE: ___/___/___

Name:_____ Date of Birth:___/___/___ Biological Sex: ☐Male ☐Female

Street Address:_____ City:_____ State:_____ Zip:_____

Primary Phone Number: _____ ☐ *Check Here if this number can receive text messages*

Email Address: _____ Occupation:_____

Emergency Contact: Name_____ Phone_____ Relationship_____

HEALTH BACKGROUND

Health & Wellness Providers seen in the last year (please check all that apply): ☐Medical Doctor ☐Chiropractor ☐Acupuncturist ☐Dentist ☐Optometrist ☐Naturopath/Natural Medicine ☐Physical Therapist ☐Psychotherapist ☐Energy Practitioner ☐Other_____

Number of medical office visits in the last year: _____ Number of hospitalizations: _____

Please select ALL implants that you may have ☐Pace Maker ☐Implantable cardioverter defibrillator (ICD) ☐Insulin pump/ glucose monitor ☐Pressure sensor in vascular system ☐Cochlear Implant ☐Neurostimulator ☐Intraocular lens ☐Artificial joints ☐Breast or other cosmetic implants ☐Hearing Aids ☐Intrauterine contraceptive devices (IUD) ☐Other bioelectronic device(s):_____

Major Surgeries (please list with approximate date): _____

_____

Significant Traumas (please list with approximate date):_____

_____

Known Allergies: _____

Weekly Exercise Habits (check all that apply): ☐**Low Activity** (less than 60 minutes per week) ☐**Moderate Activity** (Between 60 – 120 minutes per week) ☐**High Activity** (>120 minutes per week) ☐Weight Lifting/Resistance Training ☐Walking/Running ☐Biking ☐Dance/ Movement ☐Martial Arts/ Gymnastics ☐Yoga/ Pilates ☐Qi Gong ☐Other

Please describe your typical diet/eating habits: _____

_____

_____

Are you currently dissatisfied with any of the following social aspects of your life: ☐Work/Income ☐Education ☐Home ☐Marital/Love Relationship ☐Friendships/ Sense of Community & Belonging ☐Other:_____

Females

Are you currently pregnant? ☐Yes ☐No ☐Unsure ☐Not Applicable (male)

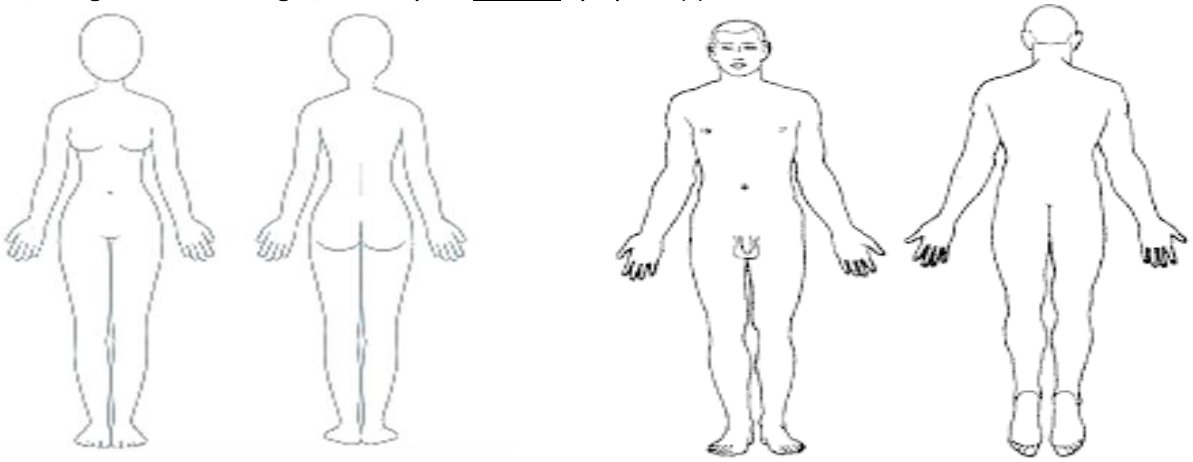
Age of first period _____ Date of Last PAP___/___/___ Date of Last Mammogram ___/___/___

1st day of last period ___/___/___ Days between periods _____ Days of Bleeding _____ Date of Menopause Onset_____

Please check any conditions that you have had in the past or current. P=past C=current

P C Condition	P C Condition	P C Condition	P C Condition
☐☐ Pain in extremities	☐☐ Grinding teeth/jaw pain	☐☐ Large weight gain/loss	☐☐ Desiring drugs/alcohol
☐☐ Cold hands or feet	☐☐ Excessive thirst	☐☐ Craving sweets/sugar	☐☐ Overly emotional
☐☐ Swollen ankles or feet	☐☐ Excessive sweating/urination	☐☐ Craving salty foods	☐☐ Bored/Lonely
☐☐ Restless legs	☐☐ Racing heart/Breathing	☐☐ Lethargy/fatigue	☐☐ Thoughts of harm
☐☐ Neck/shoulder tension	☐☐ Dizziness/light headed	☐☐ Sleep difficulties	☐☐ Fever/Chills
☐☐ Abdominal issues	☐☐ Sinus/Allergy Issues	☐☐ Low libido	☐☐ Vision problems

Please indicate, using the below images, where your <u>current</u> symptom(s) are located.



MAJOR HEALTH COMPLAINTS

Please list up to six (6) major health concerns that you would like to discuss, in order of significance to you.

1. ☐ _____ 2. ☐ _____
3. ☐ _____ 4. ☐ _____
5. ☐ _____ 6. ☐ _____

Health Concern #...	Date issue began	Frequency	Known Triggers	Describe Symptoms	Attempted Treatments	What Makes Issue Worse	What Makes Issue Better	Other family members that experience these issues?
Example	*Jan. 2014*	*Weekly*	*Too much Computer Work*	*Sharp pain/ Achy*	*Natural salves/ stretching*	*Sitting longer/ laying on side*	*Stretching with knee to chest*	*Mom*
1								
2								
3								
4								
5								
6								

Have you ever been diagnosed with any of the following health problems? Check all that apply.

☐Epilepsy or Seizures	☐Schizophrenia	☐Bi-Polar	☐Depression
☐Anxiety or Panic Attacks	☐Attention Deficit Disorder	☐Obsessive-Compulsive	☐HIV/AIDS/STD
☐Osteoarthritis	☐Fibromyalgia	☐Lou Gehrig's Disease (ALS)	☐Headaches (with aura)
☐Rheumatoid Arthritis	☐Cancer or Tumors	☐Multiple Sclerosis	☐Tuberculosis
☐Polio or Mononucleosis	☐Pneumonia or Bronchitis	☐Stroke or ATI	☐High/ Low Blood Pressure
☐Raynaud's Disease	☐Skin Disorder	☐Thyroid Disorder	☐Diabetes/ Hypoglycemia
☐Gastrointestinal Disease	☐Spleen or Lymphatic Disorder	☐Gall Bladder Stones/Disorder	☐Kidney Stones/Disorder
☐Urinary/Bladder Infection	☐Liver Disease/ Hepatitis	☐Lung/ Respiratory Disorder	☐Coronary /Heart Disease
☐Shingles (Herpes Zoster)	☐Peripheral Neuropathy	☐Frozen Shoulder/Tennis Elbow	☐Carpal Tunnel Syndrome
☐Parkinsons	☐Alzheimer's (early onset)	☐Eye Disease	☐PCOS/Endometriosis/PMS
☐Infertility/Perimenopause	☐Pre-menstrual Syndrome	☐Concussion	☐Bone Break/Fracture/Sprain
☐Muscle Spasms/Tremors	☐COVID-19	☐Chronic Fatigue Syndrome	☐Other:_____

For any items checked above, please feel free to provide additional details below including date of diagnosis, current status, treatment plans, etc. _____

_____

_____

_____

Please list current medications, including supplements and herbal remedies below: _____

_____

_____

_____

Please indicate whether you practice any of the below activities by checking the box and include frequency.

Activity	Yes	Never	Once or Twice	Yearly	Monthly	Weekly	Daily
Breathwork	☐	☐	☐	☐	☐	☐	☐
Guided Meditation	☐	☐	☐	☐	☐	☐	☐
Mindfulness	☐	☐	☐	☐	☐	☐	☐
Binaural Beats/ Sound Healing	☐	☐	☐	☐	☐	☐	☐
Other Frequency/Microcurrent Treatment	☐	☐	☐	☐	☐	☐	☐
Autogenic Training	☐	☐	☐	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐	☐	☐	☐
Intermittent Fasting/Extended Fasts	☐	☐	☐	☐	☐	☐	☐
Specific Diet Practices	☐	☐	☐	☐	☐	☐	☐
Cold Thermogenesis	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐

In addition to addressing the Major Health Concerns listed, do you have any other goals that you would like to focus on?

☐ Rediscover peacefulness/joy ☐ Establish physical well-being via ☐Nutrition or ☐Physical Movement

☐ Enhance wellness education ☐ Establish/deepen spiritual practices ☐ Achieve goals: _____

☐ Other:_____

Please acknowledge which services you are comfortable receiving by checking the respective box.

☐ Wellness Evaluation	☐ Microcurrent Therapy – Ear	☐ Sound Healing/ Toning/ Mantras/Mudras
☐ Auricular Qi Gong/ Massage	☐ Microcurrent Therapy – Body	☐ Breathwork/Relaxation/ Autogenic Training
☐ Reiki (Hands-ON or OFF)	☐ Essential Oils – Topically	☐ Cupping
☐ Bodywork & Acupressure	☐ Herbs/Oils - Aroma & Energetics	☐ Gua Sha

PLEASE CHECK IF YOU EXPERIENCE ANY OF THE FOLLOWING ON A REGULAR BASIS:

Head, Eyes, Ears, Nose, Throat

☐Glasses ☐Eye Strain/Pain ☐Red Eyes ☐Dry/Itchy Eyes ☐Bumps on Eyes ☐Night Blindness
☐Spots In Vision ☐Halos in Vision ☐Blurred Vision ☐Teeth Grinding ☐Many Cavities ☐Mouth/Lip Sores
☐Bleeding Gums ☐Dental Work ☐TMJ ☐Headaches ☐Gum Problems ☐Earaches
☐Enlarged Thyroid ☐Migraines ☐Ringing In Ears ☐Throat Tickle ☐Concussions ☐Nosebleeds
☐Hearing Loss ☐Throat Drainage ☐Excessive Saliva ☐Facial Pain ☐Lump In Throat ☐Heavy Head
☐ ☐Sore Throat ☐Swollen Glands ☐Sinus Problem ☐Sinus Drainage ☐Facial Numbness

Respiratory

☐Difficulty Breathing ☐Tight Chest ☐Pleurisy ☐Shortness of Breath ☐Asthma ☐Phlegm/Congestion
☐Rattling with Breath ☐Pneumonia ☐Chronic Cough ☐Acute Cough ☐Wheezy ☐Can't Sleep Lying Down

Cardiovascular

☐Hypertension (High Blood Pressure) ☐Chest Pain ☐Rapid Heart Rate ☐Palpitations ☐Irregular Heart Rate
☐Hypotension (Low Blood Pressure) ☐Fainting ☐Slow Heart Rate ☐Blood Clots ☐Edema (Swelling)

Gastrointestinal

☐Nausea ☐Diarrhea ☐Dark Colored Stool ☐Vomiting ☐Constipation ☐Light Colored Stool
☐Acid Regurgitation/Reflux ☐Use Laxatives ☐Mucus in Stools ☐Gas/Flatulence ☐Use Antacids
☐Blood in Stools ☐Hemorrhoids ☐Hiccups ☐Use Fiber ☐Rectal Pain/Itching
☐Bloating ☐Use Digestive Enzymes ☐Fissures ☐Bad Breath ☐Intestinal Pain
☐Vomiting Blood ☐Poor Appetite ☐Bowel Movement < 1X/Day ☐Bowel Movement > 1X/Day

Genito-Urinary

☐Pain with Urination ☐Bed Wetting ☐Impotence ☐Frequent Urination ☐Incomplete Urination
☐Dribble with Urination ☐Wake to Urinate ☐Urgent Urination ☐Frequent UTIs ☐Nocturnal Emissions
☐Kidney Stones ☐Blood in Urine ☐Increased Libido ☐Decreased Libido ☐Premature Ejaculation

Musculo-Skeletal

☐Muscle Weakness ☐Muscle Spasms ☐Muscle Cramps ☐Muscle Atrophy ☐Falls ☐Limited Range of Motion
☐Chronic Pain ☐Acute Pain ☐General Aches ☐Joint Pain ☐Arthritis ☐Joint Instability

Neurological

☐Seizures/ Epilepsy ☐Fainting/Syncope ☐Dizziness ☐Vertigo ☐Drowsiness ☐Loss of Balance
☐Poor Memory ☐Tremor ☐Convulsions ☐Paralysis ☐Stroke/CVA/TIA ☐Numbness

Neurophysiological

☐Depression ☐Worry Easily – Anxious ☐Abuse Survivor ☐Irritable ☐Unresolved Grief ☐Receiving Counseling
☐Easily Stressed ☐Frightened Easily ☐Received Counseling ☐Easily Frustrated ☐Numbness ☐Poor Memory

Skin and Hair

☐Rashes ☐Psoriasis ☐Hair Loss ☐Hives ☐Acne ☐Hair Changes ☐Ulcerations ☐Itching ☐Hair Breaking
☐Eczema ☐Dandruff ☐Thin/Slow Growing Nails ☐Fungal Infection ☐Skin Changes ☐Premature Graying

Vitality and Immune System

☐Frequent Colds ☐Chronic Mental Cloudiness ☐Slow Wound Healing ☐Frequent Flu ☐Low Energy
☐Lethargic ☐Tender/Achy All Over ☐Less Ability to Adapt

Gynecology ☐N/A

☐Currently Pregnant ☐Past Pregnancies #____ ☐Pre-Mature Births #___ ☐Miscarries #____ ☐Abortions #___
☐Decreased Libido ☐ Increased Libido ☐Hysterectomy ☐Excess Vaginal Discharge ☐PMS ☐Pain Before Menstruation
☐Pain During Menstruation ☐Pain After Menstruation ☐Vaginal Itching ☐Heavy Bleeding ☐Blood Clots
☐Spotting Between Cycles ☐Vaginal Sores ☐Vaginal Odor ☐Vaginal Dryness ☐Menopausal ☐Peri-Menopausal
☐Use HRT ☐Bone Density Changes ☐Breast Tenderness/Lumps ☐Lumpectomy ☐Mastectomy ☐Fibrocystic Breasts
Contraceptive Use: ☐None ☐Pill ☐Patch ☐Ring ☐IUD ☐Shot ☐Diaphragm/Condoms ☐Withdrawal ☐Other_____