

23198 Brook Forest Road, Abita Springs, LA 70420

985-893-4456

 **CONFIDENTIAL CLIENT INTAKE FORM**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Initial Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(will not be shared)**

**How many adults in your household? (gender/age/relationship)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many minors? (gender/age/relatioship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many pets? (type) \_\_\_\_\_\_\_\_\_\_\_ Do they live inside or outside? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Received prior massage/bodywork? Y N Indicate types: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic to any products that may be used on your skin? Specify allergen and reaction: \_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specify current medication, reason for taking, and how long you have been taking:**

**Would you like to receive information about medication side effects as they relate to your health? \_\_\_\_\_\_\_\_**

**REASON FOR VISIT**

**What is your primary concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are other areas of concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did you first notice your concerns?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was happening at or just before the time your first noticed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe what you think may have brought it on and any stressors occuring at the time:**

**What activities provide relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this condition getting worse? \_\_\_\_\_\_\_\_Interfere with work? \_\_\_\_\_\_\_\_\_Sleep?\_\_\_\_\_\_\_\_Recreation?\_\_\_\_\_\_\_**

**What changes would you like to achieve in 6 months?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_One year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Blood Type\_\_\_\_\_\_\_ Are you hyperflexible? \_\_\_\_\_\_\_\_\_\_\_**

**Are you currently under the care of another health care provider(s)? Y N Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you wear a hearing aid? Contacts? Any other prosthesis?**

**Organs surgically removed (Please note year of removal, your age at the time, organ, reason for**

**removal, and your concerns before and after):**

**Other surgical history (Please note year, your age, reason for surgery, your concerns before and after):**

**Accidents or physical traumas (include falls/injuries to sacrum/head/tailbone) (Please note year, your age, & description, which body part was affected, your concerns before and after, what emotions, if any, still arise from the trauma):**

**Birth trauma if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been diagnosed with a major illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, when, what type(s), and**

**how it resolved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How was your health as a child? Did you have frequent infections (kind)? Frequent medications (kind)?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any known reactions to vaccinations as a child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How is your health as an adult? Frequent infections(kind)? Frequent medications (kind)? \_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vaccinations as an adult and any known reactions?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check each item that is included in your usual diet:**

**\_\_red meat \_\_soy \_\_vitamin supplements medicines:**

**\_\_fish \_\_dairy products \_\_protein supplements \_\_birth control pills**

**\_\_poultry \_\_black tea \_\_herbal supplements \_\_hormone therapy**

**\_\_fruit \_\_herbal tea \_\_sugar \_\_aspirin**

**\_\_vegetables \_\_ alcohol \_\_yogurt or Keifer others: list**

**\_\_raw foods \_\_coffee \_\_fermented foods**

**\_\_nuts & seeds \_\_tobacco \_\_sodas (diet or regular?)**

**What are your favorite foods?**

**Do you eat larger and fewer meals, or smaller and more frequent meals?**

**Do you binge eat, or feel that your eating is tied to your emotions?**

**Do you drink eat more watery foods (vegetables, fruits) or more drying foods (nuts, breads, etc.)?**

**How much fluids do you drink? (include water, non-caffeinated teas)**

**Do you experience bloating / gas / burps after eating certain (or all) foods? Y N Explain:**

**Do you experience any of the following symptoms of digestive deficiency? (circle)**

**Dry mouth, gum and teeth problems, coated tongue, skipping breakfast, eat to calm down, indigestion or fullness after eating, difficulty swallowing, bloating, smelly burps, food sensitivities?**

**Do you experience any of the following symptoms of digestive excess? (circle)**

**Moist mouth, over-secretion of juices in the presence of food, pointy-tipped tongue, sore tongue, chronic nausea in the morning or when meal is delayed, irritation when taking vinegar**

**Do you experience symptoms of ulcers: gnawing pain, burning stomach relieved by eating, breath worse in morning, can only eat small amounts of food?**

**Elimination:**

**Do you poop daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do your stools sink or float? \_\_\_\_\_  Are they soft & wet or dry & hard? \_\_\_\_\_Color of feces?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have frequent diarrhea, constipation, alternate between diarrhea and constipation, blood in stool, mucus in stool, pain when stooling, hard and small pellet stools, smelly gas?**

**If you are concerned about your stool, please describe why here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other diet concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you mostly sedentary or moving during your typical day?**

**Exercise (type and amount) per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mark any areas of current persistent pain or tension on the figures below:**

**Family History**

**Family History of Abuse: Y N circle if applicable: physical emotional sexual spiritual**

**Family History of Substance Abuse: Y N Suicide: Y N Other trauma:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you have personally experienced abuse, have you been able to explore this with a professional?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Still Living?** | **Age/Cause of Death** | **Major Health Issues** |
| **Mother** |  |  |  |
| **Father** |  |  |  |
| **# of Siblings** **Your Birth Order?****Youngest, Middle,****Eldest** |  |  |  |
| Maternal Grandmother |  |  |  |
| MaternalGrandfather |  |  |  |
| PaternalGrandmother |  |  |  |
| PaternalGrandfather |  |  |  |

** Emotional & Spiritual (If you would like to share)**

**Does your work satisfy you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If not, what would rather be doing?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your opinion of yourself?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe household: Is it peaceful, supportive, disharmonious, challenging, stressful, other (explain):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is the main caregiver in your household? \_\_\_\_\_\_\_\_\_\_\_\_Does anyone in your household require**

**assisted care due to physical or mental health issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the most negative emotion you experience\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When do you most often feel this emotion?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Typically, where are you? \_\_\_\_\_\_\_**

**Are you comfortable with your weight and energy? \_\_\_\_\_\_\_ If not, what would you like it to be?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you experience nervousness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxiety? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Depression?\_\_\_\_\_**

**If so, in what situations and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you self-medicate (indicate light/moderate/heavy; daily/weekly/monthly) with: Tobacco?\_\_\_\_\_ Alcohol?\_\_\_\_\_**

**Marijuana?\_\_\_\_aspirin or NSAID? Other\_\_\_\_\_\_\_\_ Have you been you attempted or have you quit any of these**

**in the last 3 years? \_\_\_\_\_\_\_\_\_\_**

**Do you feel spiritually connected? \_\_\_\_\_\_\_\_\_\_ Do you pray or have a spiritual practice?\_\_\_\_\_\_\_**

**What hobbies/activities provide you with a sense of pleasure and accomplishment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are ways in which you take care of yourself?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On a scale of 1-10 (1 being the lesser, 10 the greater), please rate yourself in the following areas:**

**Faith\_\_\_\_\_\_ Hope\_\_\_\_\_\_\_\_ Charity\_\_\_\_\_\_ Generosity\_\_\_\_\_\_\_ Sense of Humor\_\_\_\_\_\_\_\_\_\_ Sense of Fun\_\_\_\_\_\_Fear\_\_\_\_\_\_\_ Grief\_\_\_\_\_\_\_\_\_ Other (please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please read and sign**

**I understand that a cash or check payment is due at the time of treatment unless arrangements have been made otherwise.**

**I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy.**

**I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions.**

**I understand the treatment here is not a replacement for medical care, nor is it a substitute for medical treatments and/or diagnosis and it is recommended that I see a qualified professional for physical or mental conditions that I may have.**

**I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.**

**Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**