REGENERATIONSPRINGS

23198 Brook Forest Road
Abita Springs, LA 70420
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CONFIDENTIAL CLIENT INTAKE FORM

Share only what you are comfortable sharing and that you might think is relevant

Name:_____
Address:_____
_____
Phone:_____
Partnered?_____How long?_____
Referred by:_____

Date of Initial Visit:_____
Age:_____ Date of Birth_____
Occupation:_____
Allergies to products:_____
Blood Type:_____

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 occurring at the time:

What activities provide relief? _____

What makes it worse? _____

Is this condition getting worse? _____**Interfere with work?** ___**Sleep?**_____**Recreation?**____

Medications/herbal remedies taken for symptoms?_____

What changes would you like to achieve in 6 months?_____**One year?**_____

MEDICAL HISTORY

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

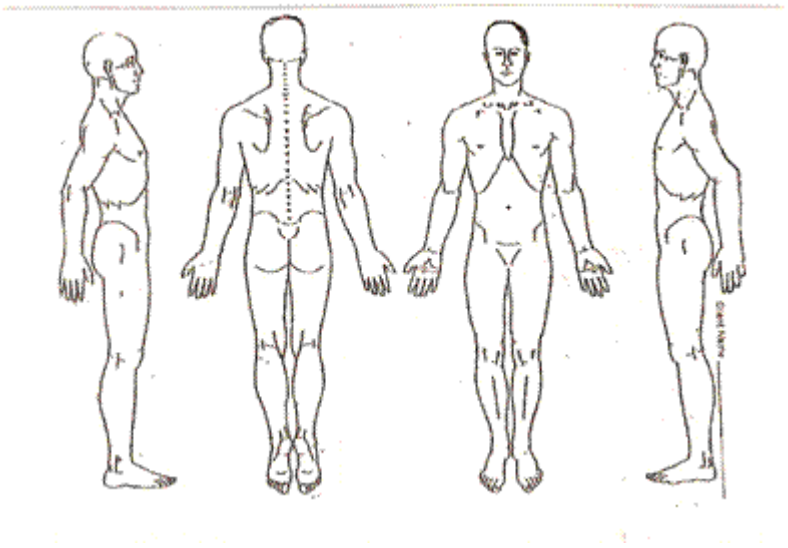
Current medications: include reason for taking and how long you have been taking them

Organs surgically removed (please note year, your age at the time, reason, and any concerns before and after):

Surgical history that did not include the removal of organs (please note year, your age at the time, reason, and any concerns before and after):

Accidents or traumas (include falls/injuries to sacrum/head/tailbone, known birth trauma) (please note year, your age at the time, reason, and any concerns before and after):

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



REPRODUCTIVE HEALTH HISTORY

(answer only if possibly relevant to your visit)

Current contraceptive method (note any challenges or concerns):

Prior contraceptive methods (note any challenges or concerns):

Is anyone in your home menstruating monthly? Menopausal?

If you menstruate, describe your cycle: include cycle length, color, consistency and volume, challenges past or present:

If others in your home environment menstruate, does this affect you? How?

Are you or another in your home environment menopausal? Does this affect you?

Do you have children? Please list dates and any pertinent information about pregnancy, labor, birth, delivery, post-partum:

Were the children breast fed? How long?_____Any complications:

Do you experience challenges to sexual relations, such as pain, erectile dysfunction, unable to achieve orgasm, frequent infections, etc.)?

Have you experienced a history of: rape trauma incest emotional abuse

If so, did you undergo counseling for this? Y N

Additional comments:

Digestion, Assimilation, Elimination

Circle symptoms you experience:

Digestive deficiency: 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?

digestive excess: 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

Ulcer: gnawing pain, burning stomach relieved by eating, breath worse in morning, can only eat small amounts of food?

Bloating / gas / burps after eating? Y N What foods trigger this?_____

What is the worse food in your diet?_____ What is the best food in your diet?_____

Do you feel the need to take supplements? Which ones, and reasons for taking:

How often are your bowel movements? What is the color?
Are they formed? Soft & wet? Dry & hard?

Do you have frequent diarrhea, constipation, alternate between diarrhea and constipation, blood or mucus in stool, pain when stooling, smelly gas?

Any other symptoms of digestion, assimilation, or elimination?

Have you had any teeth removed? If so, which ones? _____

How is your periodontal health? _____

Emotional & Spiritual

Do you find pleasure and satisfaction in your daily life?

Are you experiencing any current situations that you find challenging and need guidance in?

When and where do you most often feel negative emotions?

When and where you most often feel positive emotions?

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)_____

What are ways in which you take care of yourself?_____

Please read and sign

I agree to give at least 24 hours notice of cancellation of appointment. Cases of emergency are considered exceptions to this cancellation policy.
I understand that payment is due at the time of treatment unless arrangements have been made otherwise. Donna Caire accepts cash, check payable to Regeneration Springs, venmo (Donna-Caire) or paypal (dinojoel@gmail.com).
I understand that Donna Caire provides alternative approaches to health and well-being, and does not diagnose medical illness, disease or any other physical or mental conditions.
I have stated all my known conditions that I feel is relevant and take it upon myself to keep Donna Caire updated on my health.

Client Signature_____Date_____

Client Confidentiality Release Form

I give my permission for DONNA CAIRE to take notes about me, including health history, medical and/or personal information I choose to disclose to her. I understand that this information may be used anonymously when consulting with other practitioners.

Signature: _____Date_____