

REGENERATIONSPRINGS



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**CONFIDENTIAL CLIENT INTAKE FORM (W)**

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

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

Marital Status: Single Married Divorced How long? \_\_\_\_\_

Children: Y N Indicate sex, age, health issues and if still living at home: \_\_\_\_\_

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

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

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 and reason for taking: \_\_\_\_\_

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**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? \_\_\_\_\_

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: \_\_\_\_\_

Surgical History (year & type): \_\_\_\_\_

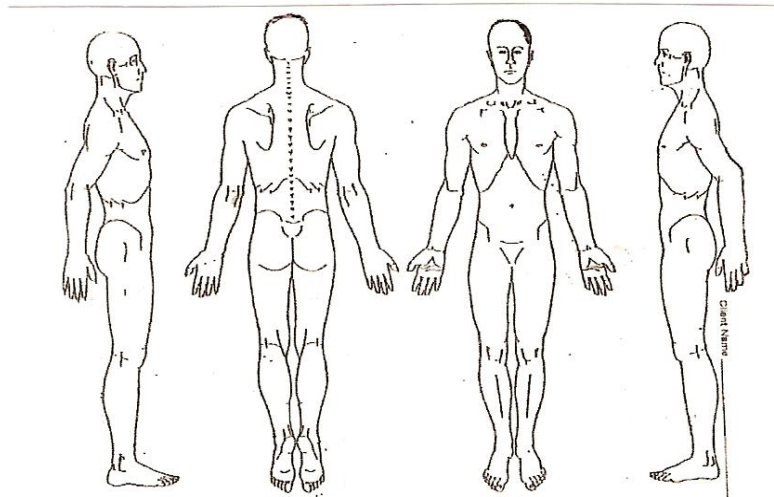
Hospitalizations: \_\_\_\_\_

Accidents or traumas: \_\_\_\_\_

Falls/injuries to sacrum/head/tailbone (describe): \_\_\_\_\_

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

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



The following symptoms are used as guidance and not viewed as "something wrong." If you experience any of the symptoms presently (or in the recent past), please mark by indicating past or present, frequently or infrequently:

### **Digestion**

Acid foods upset  
Bad breath  
Burning stomach relieved by eating (excess)  
Stomach bloating  
Lower bowel gas after eating  
Foul smelling gas  
Indigestion soon after eating  
Frequent sour stomach  
Loss of taste for meet  
Frequent vomiting (excess)  
Greasy Foods upset  
Nervous stomach  
Queasy with headache over eyes

### **Elimination**

Burning/itching anus (parasites/food sensitivity)  
Alternating constipation/diarrhea  
Stools soft and/or watery  
Irritable bowel  
Use of laxatives  
Painful bowel movements  
GI ulcers  
Stools light colored  
Boils  
Fungus  
Acne  
Psoriasis  
Itching  
Respiratory disorders

### **Viscera**

Painful breasts  
Skin peels on foot soles  
Difficulty swallowing  
Bitter, metallic taste in mouth in mornings  
Pain between shoulder blades  
Gall stones

### **Blood Sugar**

Excessive appetite

Lightheaded & feeling of hunger  
Get shaky if hungry  
Eat when nervous  
Irritable before meals  
Fatigue relieved by eating  
Afternoon headaches  
Wake in night and can't get back to sleep (adrenal)  
Moods of depression  
Crave sweets  
Headaches upon rising; wear off during day  
Diabetes

### **Cardiac/Circulation**

Swollen ankles worse at night  
Bruise easily  
Ringing in ears  
Tension/tightness under sternum  
Dizziness  
High Blood Pressure  
Low Blood Pressure  
Varicose Veins : Location \_\_\_\_\_  
Headaches: Cluster/migraines/tension

### **Muscles/Joints/Skeletal**

Painful joints  
Low back ache  
Upper back ache  
Fibromyalgia  
Sciatica  
Spinal problems  
Artificial limbs  
Arthritic

### **Endocrine**

Get chilled often  
Cold hands/feet  
Flush easily  
Irritated by strong light  
Slow to wake and get started  
Perspire easily  
Sigh frequently  
Get drowsy often  
Mental sluggishness  
Chronic fatigue

Salt craving  
Unable to relax  
Startle easily  
Tendency to asthma/allergies  
Decreased sugar tolerance  
Weight gain around hips and waist

**Food/environmental sensitivity**

Eyes/Nose Watery  
Eyelids Swollen/puffy  
Sneezing attacks  
Nightmares (histamine reaction)  
Pulse speeds after meals

**Mineral/Vitamin/EFA deficiencies**

Dry skin/ mouth/eyes/nose  
Burning/itching skin and/or feet  
Excessive hair loss/course hair  
Frequent skin rashes  
Reduced appetite  
Sensitive to hot weather  
Constipation  
Tendency to hives  
PMS  
Painful Menses  
Depression before menses  
Leg nervousness at night  
Neuralgia-like pains  
Hands & feet go to sleep easily; numb  
Worrier  
Heart pounds after retining  
Failing Memory  
Pulse below 65  
Heart palpitations  
Irritable and restless  
Can't work under pressure  
Insomnia  
Nervousness  
Highly emotional  
Eyelids/face twitch  
Hair loss  
Nails weak/ridged  
Cuts heal slowly  
Joint stiffness after rising  
Muscle/leg/toe cramps at night  
Muscle cramps worse during exercise  
Anemia  
Night sweats



### MALE REPRODUCTIVE HEALTH HISTORY

CIRCLE if currently experiencing, UNDERLINE if experienced in the past

|  |                           |                    |
|--|---------------------------|--------------------|
| Headaches (migraine, tension, cluster) | Low back pain             | Sore heels         |
| Varicose veins: location               | Numbness in legs/feet     | Depression         |
| Anxiety                                | Irritability              | Easy to anger      |
| Painful urination                      | Bladder/Kidney infections | Frequent urination |
| Nocturnal urination/frequency_____     | Changes in urinary stream |                    |
| Difficulty maintaining an erection     | Painful ejaculation       |                    |

When did you first notice these symptoms? \_\_\_\_\_ Are they getting better or worse? \_\_\_\_\_

Describe: \_\_\_\_\_

Are you taking any current medications or supplements for these symptoms? \_\_\_\_\_

If so, what kind? \_\_\_\_\_ Concerns/experience \_\_\_\_\_

Is there a history of back injury/trauma? \_\_\_\_\_ Describe: \_\_\_\_\_

Results of PSA (prostate specific antigen) Test if known: \_\_\_\_\_ Date done: \_\_\_\_\_

Results of sperm count (if applicable and known) \_\_\_\_\_ Date done: \_\_\_\_\_

Family History of Prostate Disease Y N Type: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family History of Cancer Y N Type: \_\_\_\_\_ Relationship: \_\_\_\_\_

History of Sexually Transmitted Disease Y N Type: \_\_\_\_\_ Date: \_\_\_\_\_

Are you under treatment for infertility? Y N Describe current treatment: \_\_\_\_\_

Rate your interest in sex: High Moderate Low None Do you experience pain upon intercourse? Y N

Do you have or ever had difficulty experiencing orgasms? Y N Known Reason? \_\_\_\_\_

Have you experienced a history of: rape trauma incest emotional abuse If so, when? \_\_\_\_\_

Did you undergo counseling for this? Y N What was this like for you? \_\_\_\_\_

Additional comments:

### Family History

|   | Still Living? | Age/Cause of Death | Major Health Issues |
|---|---------------|--------------------|---------------------|
| Mother  |               |                    |                     |
| Father  |               |                    |                     |
| # of Siblings<br>Your Birth Order?<br>Youngest, Middle,<br>Eldest |               |                    |                     |
| Maternal<br>Grandmother   |               |                    |                     |
| Maternal<br>Grandfather   |               |                    |                     |
| Paternal<br>Grandmother   |               |                    |                     |

|                         |  |  |  |
|-------------------------|--|--|--|
| Paternal<br>Grandfather |  |  |  |
|-------------------------|--|--|--|

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: \_\_\_\_\_

Personal History: Do you use: Tobacco? \_\_\_\_\_ /ppd Alcohol? \_\_\_\_\_ ounces/day/week/month

Marijuana? \_\_\_\_\_ Other self medications? \_\_\_\_\_ Treated for substance abuse? Y N Describe \_\_\_\_\_

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

|                                       |   |   |  |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> red meat     | <input type="checkbox"/> soy            | <input type="checkbox"/> vitamin supplements      | medicines:                                   |
| <input type="checkbox"/> fish         | <input type="checkbox"/> dairy products | <input type="checkbox"/> protein supplements      | <input type="checkbox"/> birth control pills |
| <input type="checkbox"/> poultry      | <input type="checkbox"/> black tea      | <input type="checkbox"/> herbal supplements       | <input type="checkbox"/> hormone therapy     |
| <input type="checkbox"/> fruit        | <input type="checkbox"/> herbal tea     | <input type="checkbox"/> sugar                    | <input type="checkbox"/> aspirin             |
| <input type="checkbox"/> vegetables   | <input type="checkbox"/> alcohol        | <input type="checkbox"/> yogurt or Keifer         | others: list                                 |
| <input type="checkbox"/> raw foods    | <input type="checkbox"/> coffee         | <input type="checkbox"/> fermented foods          |  |
| <input type="checkbox"/> nuts & seeds | <input type="checkbox"/> tobacco        | <input type="checkbox"/> sodas (diet or regular?) |  |

Typical Breakfast: \_\_\_\_\_

Typical Lunch: \_\_\_\_\_

Typical Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_ Water Intake (glasses) \_\_\_\_\_

Caffeine \_\_\_\_\_

What is the worse thing on your diet? \_\_\_\_\_ What foods are your weakness? \_\_\_\_\_

Are you subject to binge eating? \_\_\_\_\_ If so, what foods? \_\_\_\_\_

Do you experience bloating / gas / burps after eating? Y N What foods trigger this? \_\_\_\_\_

How often are your bowel movements? \_\_\_\_\_ Do your stools: sink float

Diarrhea \_\_\_\_\_ Constipation? \_\_\_\_\_ Blood in stool? \_\_\_\_\_ mucus in

stool? \_\_\_\_\_ Pain when stooling? \_\_\_\_\_

Supplements: \_\_\_\_\_

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

What is your exercise routine? \_\_\_\_\_

### Emotional & Spiritual

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

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

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

Do you pray or have a spiritual practice? \_\_\_\_\_

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

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

Please read and sign

I understand that 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 understand the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does she perform any spinal manipulations.

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

Client

Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist/Practitioner

signature \_\_\_\_\_ Date \_\_\_\_\_

### Client Confidentiality Release Form

I, (name) \_\_\_\_\_, give my permission for my therapist/practitioner 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 MAM practitioners.

Signature: \_\_\_\_\_ Date \_\_\_\_\_