INTAKE FORM

Initial Appointment Date_____

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work (_____)_____

Cell (_____)_____E-mail (office use only)_____

Occupation_____

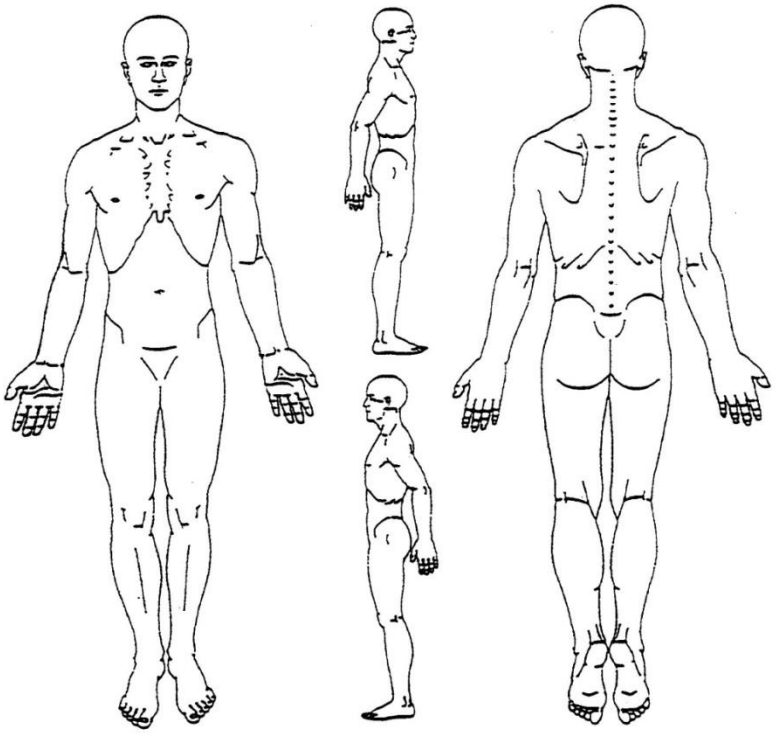
D.O.B. _____ Height_____ Weight_____Gender _____

Marital Status: Single Married Partnered Divorced Separated Widow(er)

Emergency Contact (name/number) _____

Who referred you? _____

Where exactly is the problem? Outline your discomfort in red



Rate the recent level of pain by shading in the thermometer below.

Has it been getting *BETTER* **or** *WORSE?* **(Circle one)**

Describe how it feels: *(aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating* **- if so where?***)*

How did it start the first time and this time, if this is not the first? *(Sudden or gradual onset and mechanism of injury)*

How often does it bother you?

☐ All the time ☐ _____x per week ☐ _____x per month

How long does it last once it is there?

☐ Always there ☐ _____ minutes/hours ☐ No pattern

What makes it feel worse?

What makes it feel better?

Do you have a diagnosis from a Doctor? If, yes please list it.

What other therapies/remedies have you tried? What were the results?

Have you ever had any surgeries and were they beneficial at the time?

List any other health problems for which you are being treated:

Do you have any preexisting conditions that relate to this present injury?

☐ Yes ☐ No

If yes, please explain:

Current Medications:

What do you believe caused or is causing this condition?

Do you believe it is possible to heal 100%? If not, what %? And why?

How long do you feel it will take?

How would your life improve when you resolve this issue(s)?

On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing?

1 2 3 4 5 6 7 8 9 10

Circle the level of stress you are experiencing on a regular basis on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

(please continue on next page)

General Medical History

- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune Disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal Tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug addiction
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ GERD
- ☐ Genetic Disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Infection, chronic
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Neurological problems (paralysis, Parkinson's)
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually Transmitted Disease
- ☐ Seasonal Affective disorder
- ☐ Skin Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Varicose Veins
- ☐ Other

Medical (Women)

- ☐ Menstrual Irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ PMS
- ☐ Breast Cancer
- ☐ Pelvic Inflammatory Disease
- ☐ Vaginal Infections
- ☐ Decreased Sex Drive
- ☐ STD
- ☐ Other
- ☐ Age of first period:
- ☐ Date of last gynecological exam
- ☐ Mammogram □ + □ –
- ☐ PAP □ + □ –
- ☐ Form of Birth Control
- ☐ # of Children
- ☐ # of Pregnancies
- ☐ C-Section
- ☐ Surgical Menopause
- ☐ Menopause
- ☐ Date of last menstrual cycle
- ☐ Length of Cycle:
- ☐ Days
- ☐ Interval of time between cycles
- ☐ Days:
- ☐ Any recent changes in normal menstrual flow (e.g. heavier, large clots)

Family Health History (Parents and Siblings)

- ☐ Arthritis, rheumatoid
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes

- ☐ Drug Addiction
- ☐ Easting Disorder
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Neurological Disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ 0ther:

Health Habits

- ☐ Tobacco
- ☐ Cigarettes # /day
- ☐ Cigars #/day
- ☐ Alcohol
- ☐ Wine: # glasses/ d or wk
- ☐ Beer: # glasses/ d or wk
- ☐ Liquor: # ounces/ d or wk
- ☐ Coffee: # 6 oz cups/ d
- ☐ Tea: # 6 oz cups/ d
- ☐ Soda w. Caffeine: # cans/ d
- ☐ Other Sources
- ☐ Water: # glasses/ d

Current Supplements

- ☐ Multivitamins
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/ GIA
- ☐ Calcium, source
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe
- ☐ Friendly Flora (acidophilus)
- ☐ Digestive Enzymes
- ☐ Amino Acids
- ☐ CoQ10
- ☐ Antioxidants (e.g. lutein, resveratrol, etc.)
- ☐ Herbs (teas)
- ☐ Herbs-extracts
- ☐ Chinese Herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach Flowers
- ☐ Protein Shakes
- ☐ Super-foods (e.g. bee pollen,
- ☐ Phylonutrient blends
- ☐ Liquid Meals (e.g. Ensure)
- ☐ Other:

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve you complexion
- ☐ Have stronger nails
- ☐ Have healthier nails
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, Tylenol Benadryl, Sleeping Aids
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds/flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g. cancer, heart disease, diabetes, etc.)

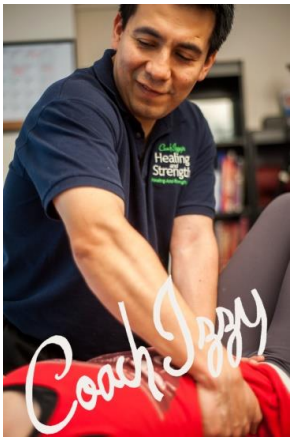
Read This!

Use this checklist to make the most out of our session:

- **Your intake form** – Have it filled out and ready to save us lengthy history intake.
- **Review our Policies and Procedures** – Read them and understand them to avoid disrupting our practice or your session. Here's the link to them: **https://healing-and-strength.com/policies-and-guidelines**
- **Location** – We've included directions to our office in the last page of this form.
- **Strenuous Exercise** – Avoid it at least 3 hours prior to your session (to prevent false diagnosis) and up to 48 hours after (to prevent flare-ups or relapses). These restrictions might change depending on your case.
- **Your Outfit and Hygiene** – Wear clean, light workout clothes, and socks. Avoid, bras with wires. Facemasks mandatory. No bandanas. Refer to my policies.
- **Prepayment Mandatory** – All sessions must be prepaid. No exceptions. Sessions without prepayment will be cancelled within two hours of booking. Use this link for full details: **https://healing-and-strength.com/rates-and-terms-of-service**
- **Be Properly Hydrated** – And avoid heavy meals, alcohol, and tobacco.
- **Finally** – Bring an open mind and a good attitude ☺

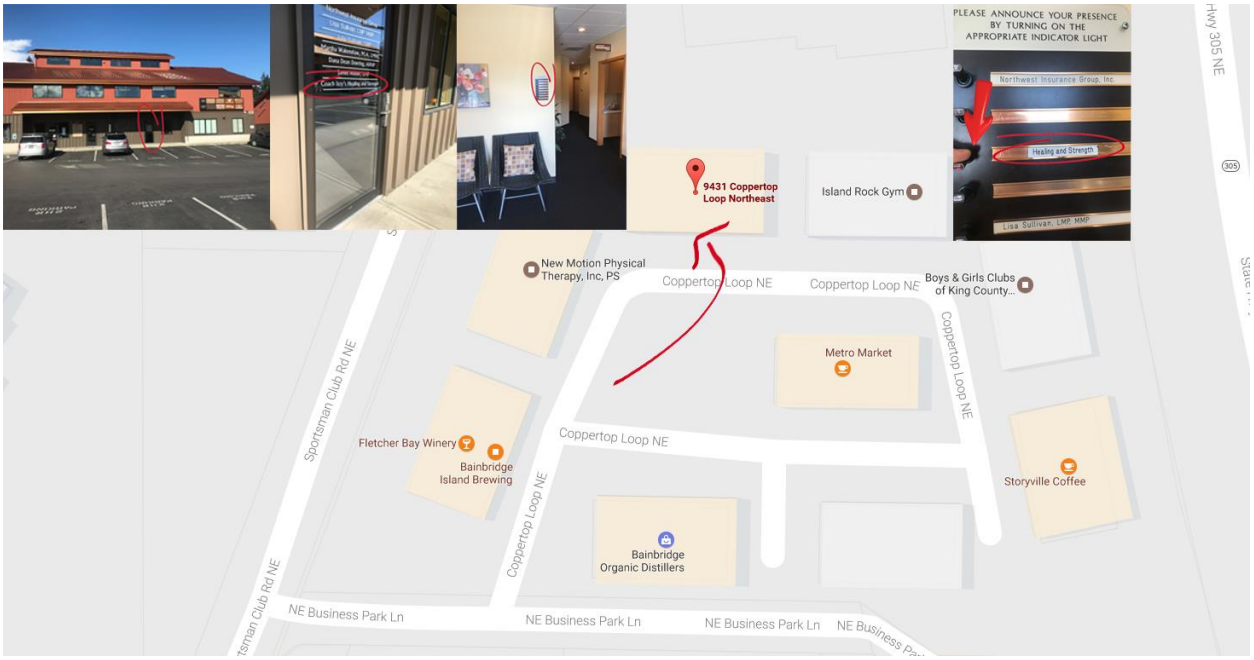
Thank you and let's make this a remarkable first step in your healing journey.

I look forward to working with you.



Directions to our Office

- Address is **9431 Coppertop Loop NE, Suite 102 A1 – A2, Bainbridge Island, WA 98110**.
- Take **Route 305** onto **Sportsman Club Road NE**.
- Turn onto **NE Business Park Ln** and make the first left **onto Coppertop Park Business Complex**.
- Make the **second right**. I'm located in the very first building on the ground floor (9431). Look for my signs.
- Please **announce** your arrival by **flipping down the toggle switch** in the directory panel in the common waiting area. I'll come out to greet you.



Call **206-201-2989 Ext. 101** if you need assistance. I'll see you soon!