enaissance Integrative Therapy, Inc.

Client Health and Wellbeing Intake Form

Name: _________________________________ DOB: ______ Age: ____
Address: ____
Phone contact(s): ____
E-mail: ____
Today's date: ________________

1) **Please describe the reason for which you seek help (list dates if appropriate).**

2) **Please provide a current list of medications and/or supplements and the condition you are taking them for.**

3) **Please list <u>any</u> surgeries, including approximate dates.**

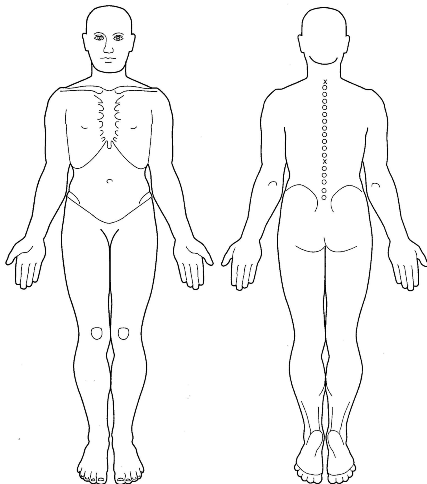
4) **List any car accidents or major falls or incidents that stick out in your mind, with approximate dates.**

5) **Please list any other kind of health care professional you are seeing/ have seen for this/these conditions:**

6) Please list any medical tests and results you have had within the past year.

7) What activities are you finding difficult or are limited because of your above conditions?

8) What are your goals for the appointment?



Please shade in areas of pain or discomfort on the body diagram and make comments below if necessary.

Please mark the symptoms that you experience.

DIGESTION:

O Loose stool or diarrhea
O Poor appetite
O Difficulty digesting oil
O Stomach or intestinal pain
O Acid reflux
O Constipation
O Excessive appetite
O Blood in stool
O Nausea/vomiting
O Heartburn
O Gas or belching
O Other: _________________

RESPIRATORY:

O Allergies
O Congestion (nasal or chest)
O Dry cough
O Nose bleeds
O Catch colds easily
O Asthma
O Wheezing
O Wet cough
O Sinus problems
O Shortness of breath
O Chest tightness
O Other: _________________
O Do you smoke? Number per day _________

CIRCULATION CARDIOVASCULAR:

O High blood pressure
O Low blood pressure
O Fast heart rate
O Dizziness
O Slow heart rate
O Chest pain
O Palpitations
O Water retention
O Too hot
O Too cold
O Cold hands/feet
O Other: _________________

URINARY:

O Painful urination
O Kidney stones
O Incontinence
O Kidney infections
O Difficulty urinating
O Other: _________________

OTHER:

O Difficulty learning
O Difficulty paying attention
O Shaky
O No thirst
O Difficulty swallowing
O Poor coordination
O Insomnia
O Poor sense of smell
O Watery eyes
O Migraines
O Abdomen/thorax pain
O Nose bleeds
O Numb/tingling. Where? ___________________________
O Muscle weakness
O Difficulty with speech
O Development / growth issues
O Dry mouth
O Poor sense of taste
O Loss of balance
O Eye pain
O Skin condition
O Poor vision
O Other eye problems?
O Nightmares
O Thirsty
O Difficulty walking
O Anemia
O Fatigue
O Poor hearing
O Dry eyes
O Headaches
O Eczema
O Joint swelling
O Lots of sleep
O Other: _________________

WOMEN ONLY:

O Breast pain or tenderness
O Heavy or excessive flow
O Are your cycles regular?
O Painful menses
O Length of cycle: ___ days
O PMS
O Other: ____

WELLBEING, EMOTIONS, and STRESS

Please circle any of the following feelings you have experienced in the past few months.

Emotional	Paranoid	Apprehensive	Annoyed
Despair	Muddled	Overwhelmed	Outraged
Helpless	Agitated	Intimidated	Obsessive
Uneasy	Nervous	Depressed	Indecisive
Impatient	Distress	Easily irritated	Intolerant
Aggravated	Fearful	Restless	Paralyzed
Uncertainty	Criticized	Overworked	Hopeless
Abused	Worried	Rejected	Persecuted
Anxious	Unable to Grieve	Guilty	Sad
Grief	Angry	Panic	

Please mark your level of stress from the listings below:

Family stress is:	O None	O Minimal	O Moderate	O Severe
Relationship stress is:	O None	O Minimal	O Moderate	O Severe
Work stress is:	O None	O Minimal	O Moderate	O Severe
Financial stress is:	O None	O Minimal	O Moderate	O Severe
Health stress is:	O None	O Minimal	O Moderate	O Severe
Other stress is: (please list below)	O None	O Minimal	O Moderate	O Severe

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Is there anything else that you would like to share, that this form didn't cover?