Renaissance 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.

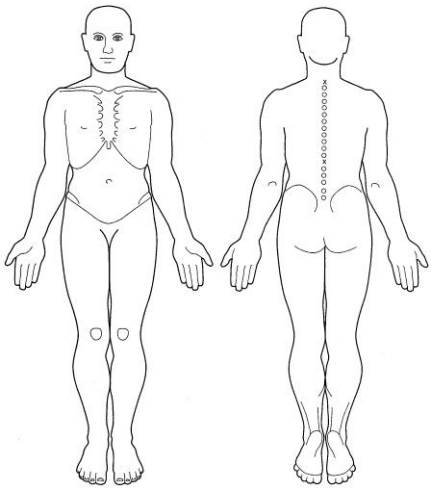
4) List any car accidents or major falls or incidents that stick out in your mind, with approximate dates.

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 this and future appointments?



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

RESPIRATORY:

O Allergies	O Catch colds easily	O Sinus problems
O Congestion (nasal or chest)	O Asthma	O Shortness of breath
O Dry cough	O Wheezing	O Chest tightness
O Nose bleeds	O Wet cough	O Other: _____

O Do you smoke? ____ no ____ yes, Number per day _____

CIRCULATION CARDIOVASCULAR:

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

URINARY:

O Painful urination	O Incontinence	O Difficulty urinating
O Kidney stones	O Kidney infections	O Urgency
O High frequency	O Other: _____	

FLUID INTAKE:

I drink water during the day: O main source of liquid O half of liquid O Never

Other fluids that I drink: O Coffee O Tea (hot or cold)
O Juice O Other fluid: _____

Alcohol intake: O None O Number of drinks per day or week: _____

OTHER:

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

WOMEN ONLY:

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

YOUR BIRTH HISTORY: O Vaginal Delivery O C-Section

Are there any specifics about your birth that you can share? i.e. umbilical cord around the neck, breech birth, any other complications or possibly no trauma, etc. _____
_____

O Breast Fed O Formula Fed

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

Emotional	Paranoid	Apprehensive	Annoyed	List any that
Despair	Muddled	Overwhelmed	Outraged	aren't listed:
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	Joyful	_____

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:	O None	O Minimal	O Moderate	O Severe

_____

Is there anything else that you would like to share that this form did not cover?