PEACE OF WELLNESS CLIENT INTAKE FORM

(CONFIDENTIAL - FOR PRACTITIONER'S USE ONLY)

Name____Date______________________________

Address____ Date & Time of Birth_________________

____ Place of Birth_______________________

Phone: Home_____________ Work______________ Fax_____________ Email___________________________

Employer/School_________________________________ Occupation/Major________________________________

Emergency Contact (name & phone)____

Relationship Status___________________ # Children_____ Ages_________ Referred by____________________

Physician (name & phone)____

Other Therapist/s (name & phone)____

Presenting Complaint____Date of Onset_____________

History of Complaint ____

Current/Previous Treatment (for above)____

Current Medications____

Current Complementary Therapies/Supplements____

Diet/Nutrition____

Activities/Exercise/Self Care____

Please list any injuries or medical conditions you have had: Do they still affect you? Is there a family history?

____

Please list any surgeries you have had or plan to have:

____

How do you release stress & tension?____

Rate 1-10: Hearing ___ Vision ___ Touch ___ Taste ___ Smell ___ Intuition ___ Ticklish ___ Tenderness ___

Order reaction to challenge (1, 2, 3): Hide/deny ___ Flight/pull ___ Analyze/push-pull ___ Fight/push ___ Freeze/stop __

Order of your reaction to stress (1 ,2, 3, etc.): Fear ___ Anger ___ Hate ___ Worry ___ Grief ___ Shame ___

Order impact of these feelings (1 ,2, 3) : Rejection ___ Abandonment ___ Humiliation ___ Betrayal ___ Isolation ___

Self Image / Need (circle your self-view): Right or Wrong Good or Bad Weak or Strong

List the top 3 features you *like* about yourself: 1. _______________ 2. _______________ 3. _______________

List the top 3 features you *dislike* about yourself: 1. _______________ 2. _______________ 3. _______________

List the top 3 *joyous* events of your life: 1. _______________ 2. _______________ 3. _______________

List the top 3 *traumatic* events of your life: 1. _______________ 2. _______________ 3. _______________

List your top 3 *goals/longings* in life: 1. _______________ 2. _______________ 3. _______________

List your top 3 *unresolved* issues in life: 1. _______________ 2. _______________ 3. _______________

What do you hope for, and what are your expectations from this session today and long-term:

____

How did you prepare for this session? ____

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Please mark the following areas of disease or symptoms as "C" for current "P" for past, and "CH" for chronic. Explain if necessary.

AUTO-IMMUNE (type)	**HEAD/EAR/NOSE/THROAT**	**NEUROLOGICAL**	**MUSCULOSKELETAL**
AIDS/HIV	Earaches	Epilepsy	Arthritis
Allergies	Headaches	Dizziness	Bone Spur
Cancer (type)	Jaw Pain	Insomnia	Bunion
Fatigue	Sinus	Migraines	Carpal Tunnel
Fever (chronic)	Other:	Other:	Gout
Fibromyalgia			Joints:
Fungal Infections (type)	**ENDOCRINE**	**REPRODUCTIVE**	- Shoulder
Hepatitis	Adrenal Insufficiency	Prostate	- Elbow
Herpes (type)	Diabetes	Testes	- Wrist
Lymes Disease	Hyperthyroid	Abortion (#)	- Finger
Mononucleosis	Hypothyroid	Endometriosis	- Hip
Skin Disorders	Pancreas	Hysterectomy	- Knee
Other:	Pituitary Dysfunction	Miscarriages (#)	- Ankle
	Spleen	Ovary	- Toe
CARDIO-VASCULAR	Thymus	Pregnancies (# &/or C)	Ligament
Angina	Other:	Sexually Trans	Muscles:
Stroke		Uterus	- Neck
Heart Attack	**MAJOR ILLNESSES**	Other:	- Shoulder
Hypertension	Chicken Pox		- Arm
Other:	German Measles	**RESPIRATORY**	- Hand
	Measles	Bronchitis	- Upper Back
GASTROINTESTINAL	Mumps	Lung	- Middle Back
Constipation (chronic)	Rheumatic Fever	Pneumonia/Pleurisy	- Lower Back
Diarrhoea (chronic)	Scarlet Fever	Tuberculosis	- Chest
Gall Bladder	Whooping Cough	Other:	- Abdomen
Gastritis	Other:		- Hip
Hepatitis		**URINARY**	- Upper leg
Hypoglycaemia		Bladder Infection	- Lower leg
Jaundice	**NERVOUS SYS / EMOTIONAL**	Kidney	- Feet
Large Intestine	Anxiety	Kidney Stones	Rheumatism
Liver Disorder	Depression	Other:	Skin
Ulcers	Eating disorder		Tendon
Flatulence	Mood swings	**VISION**	Vertebrae / Spine:
Pancreas	Sciatica	Contacts	- Cervical (neck)
Small Intestine	Substance abuse	Far Sighted	- Thoracic (back)
Stomach	Suicide Attempt (#)	Near Sighted	- Lumbar (low back)
Other:	Other:	Other:	Other: