Client Confidential Intake Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Home Number _____ Cell Number_____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

____ Yes ____No

Please Explain:

Please circle your stress level:

Low 1 2 3 4 5 High

Are you allergic to any Lotions or Oils? ____ Yes ____ No

Please Explain:_____

Intake Form

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other:_____

Nervous System

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia

Other

Loss of Appetite
Depression
Difficulty concentrating

Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other:_____

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

Reproductive System

Pregnancy

Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Other:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Hospitalizations _____

_____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe)_____

Female Reproductive Health History

When did you begin your menses_____**What was this like for you**_____

How many Pregnancie(s) have you had?_____**Number of Deliverie(s)**_____**Dates**_____

Termination(s)_____**When**_____

Miscarriage(s)?_____**When**_____

Complications_____

What was your experience of: *Pregnancy*_____

Labor_____

Delivery_____

Post Partum_____

Medications your mother took when she was pregnant with you (if any)_____
Birth Trauma if known _____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis------PMS Menopause

Cancer(type)_____**Menstrual Problems Other**_____

Method of Contraception (circle) pills patch diaphram injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____**Length of time using method**_____

Last Pap smear_____Results (if known)_____

Date of Last Menstrual period_____ Length of Menses_____ Are you Pregnant/Trying to Conceive_____

Episodes of Amenorrhea_____When_____For how long_____

Painful Periods	**Irregular Cycles (early or late)**
Dark, thick blood at beginning of cycle cycle	**Dark thick blood at the end of cycle**
Headache or Migraine with period	**Dizziness with period**
Bloating/Water Retention with period	**Heaviness in pelvis with period**
PMS/Depression with or before period	**Excessive Bleeding (> one pad/hour)**
Failure to Ovulate	**Painful Ovulation**
Varicose Veins	**Tired weak legs**
Numb legs and feet when standing	**Sore heels when walking**
Low back ache	**Painful intercourse**
Constipation	**Endometriosis**
Endometritis/Uterine Infections	**Uterine Polyps**
Fibroids	**Vaginal Discharge/Vaginitis/**
Bladder Infections/Incontinence	**Chronic Miscarriage**
Weak newborn infants	**Premature deliveries**
Incompetent cervix	**Spotting with pregnancy**
Pelvic Inflammation	**Sexually Transmitted disease**
Dry Vagina	**Difficult menopause**
Cancer esp of reproductive area	**Cysts esp breast/ovarian**
Other:	

Are you under the treatment for Infertility_____Describe current treatment to date :_____

(IUI, IVF,etc)_____

Gynecological Provider:_____Address_____Phone_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest____If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

Agreement

I understand that Suzi Wilkoff does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times . I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the session, and they will end the session. I understand that the practitioner may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status. I have received a copy of this agreement and cancellation policy.

Cancellation Policy
48 Hours Notice Required for Changes or Cancellations. Full session fee will be charged for less than 48 hours notice. Please inform me if you have an emergency or circumstance beyond your control.

Client's signature_____ Date_____