Therapy Intake Form

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Today's Date: _____

Name: _____Phone: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____Referred by: _____ _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Please review the following conditions and circle: "Y" if it applies to you or "N" if it doesn't apply to you. If you circle "Y" please describe applicable information in the space provided below.

Y N Do you frequently suffer from stress?
Known cause(s)? _____

Y N Do you have digestive issues?
Explain: _____

Y N Do you have diabetes?
Explain: _____

Y N Do you have any allergies?
Explain: _____

Y N Do you experience frequent headaches?
Known cause? _____

Y N Do you have numbness/tingling?
Where? _____

Y N Do you suffer from arthritis?
Where? _____

Y N Do you have chronic fatigue?
Explain: _____

Y N Do you have cardiac or circulatory problems?
Explain: _____

Y N Do you have hormone imbalances?
Explain: _____

Y N Do you suffer from epilepsy or seizures?
Explain: _____

Y N Do you have PMS?
Explain: _____

Y N Do you have varicose veins?
Where? _____

Y N Do you have cancer?
Explain: _____

Y N Are you pregnant?
How far along? _____

Y N Do you have chronic pain?
Where? _____

Y N Are you taking any medications?
What? _____

Y N Do you suffer from depression?
Explain: _____

Y N Do you have any eating disorders?
Explain: _____

Y N Do you have any communicable diseases?
Explain: _____

Other Conditions/Comments:
_____

_____

Please explain your quality of sleep. How many hours of sleep do you average nightly?

_____

_____

Turn over →

Please describe what a typical week of exercise looks like for you. Do you feel you get enough exercise? Y / N

_____

_____

Please explain your experience with bodywork and other healing modalities: frequency and other applicable information.

_____

_____

Please list relevant health issues, illnesses, traumas, accidents, falls or surgeries (please include dates if you can).

_____

_____

List in order your 3 primary goals of receiving treatment today.

_____

_____

_____

(Initial) **Client Agreement**

_____I understand that treatments are given for the well-being of my body and mind and I agree to communicate with Jolene if at any time I feel like my well-being is being compromised.

_____I affirm that I have stated all my known medical conditions above to the best of my knowledge.

_____I agree to inform Jolene of changes related to my medical profile and understand that there shall be no liability on Jolene's behalf should I fail to do so.

_____I understand that treatments are non-sexual and Jolene may discontinue treatment if there are any sexual advances or remarks are made.

_____I understand Jolene not a Psychotherapist and her intention is to encourage clients to express how they are feeling, in order to see how psychological and emotional disturbances contribute to physical imbalances in their body.

_____I agree to make full payment to Jolene by the end of each treatment.

_____I understand that cancellations must be made 48 hours in advance and I will be charged a $55 cancellation fee in failure to do so.

Your signature below signifies that you agree to uphold the Client Agreement.

Client Signature: _____Date: _____

Turn over →