Wellness Intake Form

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Date _____

Name _____ Cell Phone _____

Address _____ Work Phone _____

City/State/Zip _____ Home Phone _____

Occupation _____ Email _____

Marital Status ○ Married ○ Single ○ Widow ○ Divorced ○ Separated Emergency Contact _____

Number of children _____ Emergency Phone _____

Birth Date: Month _____ Day _____ Referred by _____

Height _____ Weight _____ Age _____

Health concerns for which you came today _____

When did the condition develop & describe symptoms & diagnosis given _____

What makes this condition worse? _____

List treatment currently prescribed for this condition _____

Describe results of previous treatment(s): (chiropractic, massage, PT, etc) _____

Are you presently under a physician's care: (Other than annual physicals) ○ Yes ○ No

If so, please explain _____

List surgeries, accidents & illnesses (dates) _____

List medications & reason for their use _____

List over-the-counter medications & supplements _____

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Do you regularly drink caffeine beverages ○ none ○ coffee ○ tea ○ coke ○ other _____

Do you smoke? ○ Yes ○ No If so, how many packs a day? _____

Do you drink alcoholic beverages? ○ Yes ○ No If so, how much? _____

Are you pregnant? ○ Yes ○ No If so, what is the expected delivery date?_____

Are you participating in a regular fitness program? ○ Yes ○ No

If so please describe _____

_____

How many hours a night do you sleep? _____ Is your sleep restful? ○ Yes ○ No

If not, at what times or how often do you wake _____

Do you have trouble ☐ falling asleep ☐ staying asleep ☐ neither

Do you have any medical condition and/or physical limitation that your practitioner needs to be aware of before you receive treatment? ○ Yes ○ No

If so, please explain_____

_____

Please check all the areas of pain below

Upper Body	Back	Arms	Legs
☐ Head	☐ Upper	Shoulder ☐ Left ☐ Right	Hip ☐ Left ☐ Right
☐ Neck	☐ Middle	Elbow ☐ Left ☐ Right	Knee ☐ Left ☐ Right
☐ Chest	☐ Lower	Wrist ☐ Left ☐ Right	Ankle ☐ Left ☐ Right
☐ Abdomen	☐ Sacrum	Hand ☐ Left ☐ Right	Foot ☐ Left ☐ Right
	☐ Sacroiliac Joint		

Other _____

_____

_____

Please check any of the following feelings you have experienced in the last few months:

☐ Abused	☐ Rejected	☐ Overwhelmed	☐ Unable to grieve	☐ Fearful	☐ Intolerant	☐ Outraged
☐ Criticized	☐ Despair	☐ Muddled	☐ Apprehensive	☐ Impatient	☐ Uncertainty	☐ Nervous
☐ Overworked	☐ Helpless	☐ Persecuted	☐ Agitated	☐ Intimidated	☐ Aggravated	☐ Worry
☐ Paralyzed	☐ Hopeless	☐ Guilty	☐ Uneasy	☐ Restless	☐ Annoyed	☐ Anxiety
☐ Depressed	☐ Paranoid	☐ Easily irritated	☐ Distress	☐ Panic	☐ Angry	

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Please check any of the symptoms you experience Sometimes Often Past (Leave BLANK if NEVER)

○	○	○	Loose stools/Diarrhea	○	○	○	Cough
○	○	○	Flatulence	○	○	○	Shortness of breath
○	○	○	Vomiting	○	○	○	Decreased sense of smell
○	○	○	Belching, Burping	○	○	○	Nasal problems
○	○	○	Heartburn	○	○	○	Skin problems
○	○	○	Feeling of distension after meals:	○	○	○	Bronchitis
				○	○	○	Asthma
○	○	○	Obsessive in work / relationships	○	○	○	Tendency to catch colds easily
○	○	○	Fatigue	○	○	○	Intolerant to weather changes
○	○	○	Edema	○	○	○	Allergies
○	○	○	Easily Bruised	○	○	○	Hay Fever
○	○	○	Difficult to stop bleeding	○	○	○	Irritable bowel
○	○	○	Low back pain	○	○	○	Constipation
○	○	○	Knee problems	○	○	○	Hemorrhoids
○	○	○	Hearing impairment	○	○	○	Blood in stools
○	○	○	Ringing in ears				
○	○	○	Kidney stones	○	○	○	Eye problems
○	○	○	Decreased sex drive	○	○	○	Dizziness
○	○	○	Hair loss	○	○	○	Hepatitis
○	○	○	Urinary problems	○	○	○	Difficulty digesting oily foods
				○	○	○	Gall stones
○	○	○	Insomnia, difficulty sleeping	○	○	○	Light colored stools
○	○	○	Heart palpitations	○	○	○	Soft or brittle nails
○	○	○	Excessive dreaming	○	○	○	Easily angered / irritated
○	○	○	Restless	○	○	○	Difficulty making plans or decisions
○	○	○	Chest pains	○	○	○	Muscle spasms / twitching
○	○	○	Tendency to faint easily	○	○	○	Headaches
○	○	○	High Blood pressure	○	○	○	High cholesterol
○	○	○	Abdominal hernia	○	○	○	Neck pain
○	○	○	Arthritis	○	○	○	PMS
○	○	○	Sciatica	○	○	○	Severe menstrual pain
○	○	○	Bursitis	○	○	○	Severe irritability
○	○	○	Blood clots	○	○	○	Severe depression
○	○	○	Broken bones	○	○	○	Foot numbness
○	○	○	Hand/feet cold	○	○	○	Carpal tunnel syndrome
○	○	○	Hand numbness	○	○	○	TMJ (temporal-mandibular joint)
○	○	○	Cancer	○	○	○	Loss of balance
○	○	○	Herniated disc	○	○	○	Diabetes
○	○	○	Varicose veins				

Consent and Disclosure Agreement

I, _____(Print Name; if minor, include name of a parent) understand my sessions include a mind-body approach intended to enhance relaxation and increase communication between the mind and the body.
Please read and initial the following statements:

Any information provided by the Practitioner is educational and to be used at my discretion. ○ I agree.

I know that the Practitioners at The Retreat are not medically licensed doctors and will not diagnose, treat, or prescribe for illness, injury, disease, or other pathological condition, or perform any act which constitutes the practice of medicine. I understand that sessions are not substitutes for medical treatment or medications. ○ I agree.

I understand that I may experience so-called "detoxification symptoms" or releases during the 24-48 period following the session and that these may be uncomfortable if my current level of stress is heightened. ○ I agree.

I understand participation in a session is voluntary and at any time I may choose to end my participation. In addition, the session may entail light tapping and contact of energy points of the body. The Practitioner will inform me where tapping and/or contact (by the practitioner and/or myself) will occur, thus allowing for ongoing consent. ○ I agree.

It is my responsibility to inform my Practitioner of any medical conditions or medications I am currently taking. I understand that although I may seek information and counseling from my practitioner, my health and well-being or that of my child, is my own responsibility. It is my responsibility to consult my primary care provider or to seek out other medical help when necessary. ○ I agree.

All information exchanged will be considered confidential and will not be released without written consent, or as required by law. ○ I agree.

I understand that by providing this informed consent I am assuming full responsibility for my Mind Body Energy or Resistance Flexibility Session(s) and I hold harmless both the Practitioner and location where the session is done. ○ I agree.

Session Charges:		Springman
Initial session:	75 min	$175
Follow-up sessions:	60 min	$150
Extra time	per 15 min	$25

Remote sessions are charged the same as office visits. ○ I agree.
Payment is expected at the time of services. ○ I agree.
I consent to receive and pay for any and all remote sessions per the standard rate. ○ I agree.
I understand a 24-hour cancellation notice is expected and missed appointments will be charged at a rate of $50. ○ I agree.

If I have any questions or concerns, I will address these promptly with the practitioner. I authorize the practitioner to provide me (or the child/dependent listed above) with Session(s). ***If submitting this form by email and signature is not typed or signed, it is understood that by emailing the form that I agree to the terms listed above.***

Sign or Type Name _____Date _____

Practitioner _____Date Reviewed _____

Helpful Suggestions for an optimal Mind Body Session

*Please bring the completed intake form to your first appointment.

*Read all materials carefully and make note of any questions you wish to discuss.

*During your session, you will be lying face up on a massage table. Please wear natural fiber clothing, like cotton. It is especially important that you avoid wearing any nylon, spandex, or metal, including under wire bras if possible. Jewelry, glasses and shoes can be removed prior to your session.

*Please arrive early in order to enjoy the full time of your appointment. Late arrivals may result in your session being limited due to time constraints.

***Please give at least 24 hours notice when canceling an appointment.