PAMPERED SPIRIT- A Touch That Heals
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CLIENT INTAKE LONG FORM

(CONFIDENTIAL-FOR PRACTITIONER'S USE ONLY)

Name _____ Email _____ Date _____

Address _____ City _____ Zip Code _____

Date of Birth _____ Height _____ Weight _____ Occupation _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact: Name _____ Phone _____

Status: M S W D Spouse or Significant Other's Name _____

# of Children ____ # of Step Children ____ Names in birth order: _____
_____

Reason for Visit (add details on back if necessary) _____

Date of Onset _____

Physician/Therapist (name & phone) _____

Other Professionals _____

Current Medications _____

Current Complementary Therapies/Supplements _____
_____

Eating Habits/Diet _____
_____

Allergies _____

Amount Daily Intake: Water (oz) ____ Caffeine _____ Alcohol _____ Cigarette/Tobacco _____

Exercise routine, be specific _____

Vision: Wear contacts/glasses _____ Smell _____ Hearing _____ Taste _____

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Please CIRCLE the following areas of disease or symptoms. We will go through and discuss.

Depression	Epilepsy	Bronchitis	Sexually Trans. Disease
Eating disorder	Dizziness	Pneumonia/Pleurisy	Endometriosis
Mood swings	Insomnia	Tuberculosis	Pregnancies (# & if current)
Substance abuse	Migraines		Miscarriages (#) ____
	Headaches (recurrent)		Abortion # ___
Allergies	Rheumatism	Diarrhea (chronic)	
Cancer (type) _____	Back Pain	Gastritis	
Fatigue	Carpal Tunnel	Hepatitis	Chicken Pox
Fever (chronic)	Gout	Hypoglycemia	Measles
Fibromyalgia	Skin Disorder (type)	Jaundice	German Measles
Fungal Infections (type)		Liver Disorder	Mumps
Herpes (type)	Earaches (chronic)	Ulcers	Whooping Cough
Lymes Disease	Jaw Pain	Flatulence	Rheumatic Fever
Mononucleosis	Teeth	Pancreatitis	Scarlet Fever
Endocrine	Cardio-Vascular	Urinary	
Adrenal Insufficiency	Angina	Bladder Infection	
Pituitary Dysfunction	Heart Attack	Kidney Stones	Other _____
Hyperthyroid	Heart Failure	Prostate Disease	
Hypothyroid	Hypertension/stroke	Incontinence	

List any noteworthy injuries/accidents you have experienced. _____
_____

List any surgeries you have had (or future plans for surgery). _____
_____

List any traumatic or life threatening events that occurred in your life and when they happened. (IE: Separation, divorce, deaths, depression, post-traumatic stress, or other significant event(s))
_____
_____

List any work place incidents or people that influence your health. _____
_____
_____

Please indicate any mental stress, signs or symptoms that you are experiencing and the reason if known. _____
_____

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Have you been under any treatment for these conditions? Please explain.
_____
_____

Indicate any events, situations or feelings that influence your emotional health.
_____
_____

Indicate any spiritual issues, beliefs or religious images that influence your health.
_____
_____

In general, is there anything else you want to share, or want me to know?
_____
_____

What is your connection with spirituality/religion? IE: religious background, soul development, current practices. _____
_____

Brothers/sisters in order of birth:
Oldest_____2nd_____3rd_____Etc._____
_____

Relationship with mother as a child _____

Present relationship _____
_____

Relationship with Father as a child _____

Present relationship _____
_____