

HEALTH ALTERNATIVES, LLC
1015 4TH AVE WEST SUITE A/B
OLYMPIA, WA 98502
CLIENT INTAKE FORM

Client Name _____ Date _____

Client Information

Address _____
City _____ State _____ Zip _____
Phone (Home) _____
Work _____ Cell _____
E-mail _____
Date of Birth _____ Gender: M F
Employer _____
Occupation _____
Marital Status: Single Married Partnership Divorced
 Separated Widowed
Spouse/Partner Name _____
of Children _____
Emergency Contact _____
Contact Phone: Home _____
Work _____ Cell _____

Have you ever received Energy Therapy before?
o Y o N Frequency? _____
Have you ever received Manual Therapy before?
o Y o N Frequency? _____
Have you ever received Psycho Therapy before?
o Y o N Frequency? _____

List all conditions currently monitored by a Health Care
Provider. _____

Primary Health Care Provider

Name _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

List Daily Activities
Work _____
Home/Family _____
Social/Recreational _____

I give my therapist permission to consult with my health care
provider regarding my health and treatment.

Circle the above activities affected by your condition.
o all of the above
Check other activities affected:
o sleep o washing o dressing o fitness
How do you reduce stress? _____

Comments _____
Initials _____ Date _____

Pain? _____

Current Health Information

List Health Concerns (Check all that apply and explain)
Primary _____

What are your goals for receiving Therapy?

Mild Moderate Disabling
 Constant Intermittent
 Symptoms ↑ w/activity ↓ w/activity
 Getting worse getting better no change
Treatment received _____

Health History

List & include dates & treatments. Add pages if necessary.
Surgeries _____

Secondary _____

Accidents (physical-psychological) _____

Mild Moderate Disabling
 Constant Intermittent
 Symptoms ↑ w/activity ↓ w/activity
 Getting worse getting better no change
Treatment received _____

Major Illnesses _____

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Health History cont'd...

Women

Last Pap _____
 First day of last menstrual period _____
 Marital/Partner History (Years Married) _____
 Number of Children _____
 Ages of Children _____
 Number of pregnancies _____
 Complications _____
 Use of Contraceptive o Y o N
 What type? _____
 Abortions? _____

Lifestyle Factors

Exercise Activities Please fill in the approximate amount

Type	Never	Minutes	Hours	Weekly	Daily
Swim					
Run					
Walk					
Dance					
Bike					
Garden					
Golf					
Tennis					
Ski					
Weights					
Yoga					
Pilates					
Other					
Other					

Habits

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	tobacco _____
<input type="checkbox"/>	<input type="checkbox"/>	alcohol/drugs _____
<input type="checkbox"/>	<input type="checkbox"/>	coffee/soda _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Nutrients/Herbs

Supplements	Manufacturer	Form	Dosage	Frequency
<i>eg: Vit C</i>	<i>Bronson</i>	<i>Tablet</i>	<i>500 mg</i>	<i>2/day</i>

Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother:

Father:

Brothers & Sisters:

Mother's Parents:

Father's Parents:

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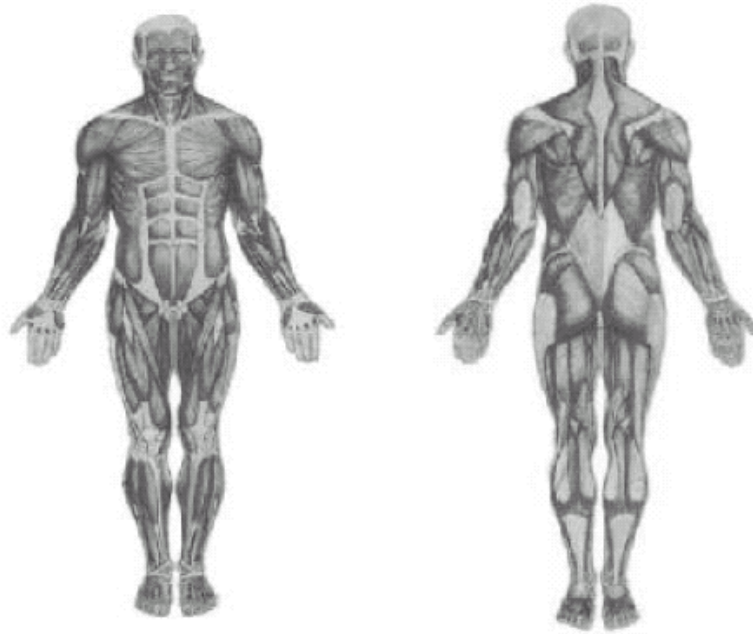
Diet Log

Please write down what you eat and drink for three days. This includes juice, coffee and alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table.

Meal	DAY 1	DAY 2	DAY 3
Breakfast			
Snack			
Lunch			
Snack			
Dinner			

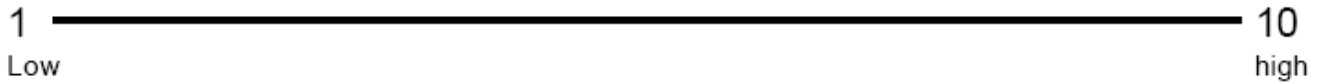
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Mark areas of pain/discomfort:



List any other issues you would like to have addressed during your session(s):

Rate your stress level as of today



Check all Current and Previous Conditions please explain

General

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	pain _____
<input type="checkbox"/>	<input type="checkbox"/>	sleep disturbances _____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue _____
<input type="checkbox"/>	<input type="checkbox"/>	infectious in the ears _____
<input type="checkbox"/>	<input type="checkbox"/>	fever _____
<input type="checkbox"/>	<input type="checkbox"/>	sinus _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Skin Conditions

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rashes _____
<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Allergies

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions _____
<input type="checkbox"/>	<input type="checkbox"/>	detergents _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Muscles and Joints

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis _____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones _____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems _____
<input type="checkbox"/>	<input type="checkbox"/>	disk problems _____
<input type="checkbox"/>	<input type="checkbox"/>	lupus _____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain _____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps _____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains _____
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis, bursitis _____
<input type="checkbox"/>	<input type="checkbox"/>	stiff or painful joints _____
<input type="checkbox"/>	<input type="checkbox"/>	weak or sore muscles _____
<input type="checkbox"/>	<input type="checkbox"/>	neck, shoulder, arm pain _____
<input type="checkbox"/>	<input type="checkbox"/>	low back, hip, leg pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Nervous System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	head injuries, concussions _____
<input type="checkbox"/>	<input type="checkbox"/>	dizziness, ringing in the ears _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of memory, confusion _____
<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling _____
<input type="checkbox"/>	<input type="checkbox"/>	sciatica, shooting pain _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic pain _____
<input type="checkbox"/>	<input type="checkbox"/>	depression _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Respiratory, Cardiovascular

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	heart disease _____
<input type="checkbox"/>	<input type="checkbox"/>	blood clots _____
<input type="checkbox"/>	<input type="checkbox"/>	stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	lymphadema _____
<input type="checkbox"/>	<input type="checkbox"/>	high, low blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat _____
<input type="checkbox"/>	<input type="checkbox"/>	poor circulation _____
<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles _____
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins _____
<input type="checkbox"/>	<input type="checkbox"/>	other o pregnancy _____
<input type="checkbox"/>	<input type="checkbox"/>	chest pain, shortness of breath _____
<input type="checkbox"/>	<input type="checkbox"/>	asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	palpable heartbeat in abdomen _____

Digestive/Elimination System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	bowel dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain _____
<input type="checkbox"/>	<input type="checkbox"/>	ulcers, colitis _____

other _____

Endocrine System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____

current past comments o o other

Reproductive System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy _____
<input type="checkbox"/>	<input type="checkbox"/>	reproductive problems _____
<input type="checkbox"/>	<input type="checkbox"/>	painful, emotional menses _____
<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts _____

Cancer/Tumors

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	benign _____
<input type="checkbox"/>	<input type="checkbox"/>	malignant _____