MASSAGE & MEDITATION

OLGA VICTORIYA

WELLNESS GOALS INTAKE

Name (print) _____

Birth Date_____Gender (circle) F / M

Social Support/Living Situation (family, alone, pets, etc) _____

_____

Occupation_____

Telephone_____E-mail_____

Referred By_____

Emergency Contact / Guardian_____

What is your personal stress level now:

Use scale from 0 (no stress) to 10 (extreme)

From: Illness_____Work_____Relationships_____Finances_____Loss_____

What is your energy level Now:

Use scale from 0 (no energy) to 10 (lots of energy) _____

What is your primary complaint(s) today:_____

Health Practitioner Seen (circle)

Physician / Nurse Practitioner / Physical Therapist / Nutritionist / Chiropractor / Acupuncturist / Counselor / Other

Reason: _____

Water Intake / Glasses per day_____

Nutrition (circle) Healthy / Unhealthy / Vegan / Vegetarian / Raw Food / Other (explain)_____

Digestion (circle) Regular / Constipation / Loose / Indigestion / Gas / Bloating / Nausea / Vomiting / Heartburn / Hunger / No Appetite / Other explain)_____

Sleep Patterns (circle) Insomnia / Sleep Aids / Naps / Wake at Night / Other (explain)_____

During the day do you feel (circle) Fatigue / Weak / Hard to Concentrate / Poor Memory / Dizziness / Lightheaded / Sudden Energy Drop / Other (explain)_____

Do you use (circle) Coffee / Soda / Alcohol / Tobacco / Caffeine / Recreational Drugs and frequency_____

Self Care (circle) Exercise / Meditation / Massage / Hobbies / Support Groups / Friends / Other (describe)_____

frequency_____

Did you have any vaccinations in your childhood (circle) Yes / No

Do you get flu shots every year? Yes / No

Do you experience any of these emotions (circle) Anger / Anxiety / Depression / Fear / Sadness / Doubt / Worry / Grief / Irritability / Obsessive thinking / Guilt / Frustration / Negative Thinking / Envy / Jealousy / Shame / Despair / Others (describe)_____

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CLIENT INTAKE

HAVE YOU SEEN A DOCTOR IN THE LAST 2 YEARS Yes / No

Explain_____

LIST OF MEDICATIONS YOU TAKE _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Heart Yes / No

Explain_____

Diabetes Yes / No

Type_____

Blood Yes / No

Explain_____

Thyroid Yes / No

Explain_____

Epilepsy Yes / No

Frequency_____

Lungs Yes / No

Explain_____

Oncology Yes / No

Explain_____

Mental Issues Yes / No

Explain_____

Kidney / Urinary Yes / No

Explain_____

Infections Yes / No

Explain_____

Hepatitis Yes / No

Type_____

Liver Yes / No

Explain_____

Arthritis Yes / No

Type_____

Asthma Yes / No

Explain_____

Digestion Yes / No

Explain_____

Neuropathic Yes / No

Explain_____

Allergies Yes / No

Explain_____

Tuberculosis Yes / No

Explain_____

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CLIENT INTAKE

For Women Only - are you pregnant or trying to become? Yes / No
IF YES then how many Weeks?
Do you have PMS, Menopause, other_____
Did you ever took or are you taking now birth control (circle) Yes / No
For Male Only - do you have prostate problem, erectile disfunction, other_____

List of Supplements, Herbs, etc:_____
_____
_____
_____

List of your Complains and Symptoms: _____
_____
_____
_____

What do you believe is the reason for your current health state? _____
_____
_____
_____

Client signature:_____Date:_____