Confidential Intake Form

Date of Initial Visit_____

Name: _____

Address_____

State _____ Zip _____Home Phone_____

Work Phone_____Cell_____email_____

Date of Birth _____ Age _____

Female _____ Male_____ Other_____ Preferred Pronoun_____

Occupation_____

Marital/Relationship status _____ Referred by_____

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name) _____address _____

give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her. I understand this information may be used for the purpose of practitioner certification and/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, social security number, date of birth.

Client Signature: _____ Date: _____

Practitioner signature_____Date:_____

Deborah Doering Austin, RN, DN Kamala Center For Radiant Health, PLLC, Houston, TX
www.kamalahealth.com 832-818-0186 docdeb@kamalahealth.com

Reason For Visit

Primary reason for visit: _____

When did your first notice it? _____What brought it n? _____

Describe any stressors occurring at the time_____

What activities provide relief? _____what makes it worse? _____

Is this condition getting worse? _____interfere with work _____sleep _____recreation _____

Have you had massage/bodywork before? _____ What type? _____

Medical History

Are you currently under the care of another health care provider(s)? _____Reason (s) _____

_____

Name(s) of Practitioner_____Address:_____

Phone_____Email_____

Current Medications and /or Supplements/Remedies: _____

_____

Allergies: specify allergen and reaction: _____

Surgical History (year and type) and/or Recent Procedures: _____

_____

Hospitalizations: _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

Other:

I understand that payment is due at time of service unless arrangements have been made otherwise.

24 hours notice is required via telephone for changes or cancellations in order to better serve you and others. Full payment is required for No Shows and day of service cancellations, and must be received before additional appointment is booked.

Client signature:_____ Date:_____

Deborah Doering Austin, RN, DN Kamala Center For Radiant Health, PLLC, Houston, TX
www.kamalahealth.com 832-818-0186 docdeb@kamalahealth.com

Please review and check the following:

Headaches Type:	Past	Present	Numbness in feet or legs when standing	Past	Present
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other (not mentioned above):

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____Water Intake (glasses/day) _____Caffeine_____

Do you use Tobacco? _____ Quantity_____/ppd Alcohol? _____ Quantity _____ounces/day

Marijuana? _____Quantity _____Other: _____Have you been under treatment for substance use?

What is the worst item in your diet _____What foods are your weakness_____

Are you subject to binge eating? _____What foods_____

Do you experience bloating/gas/burps after eating? _____What foods trigger this? _____

How often are your bowel movements? _____Do your stools: sink _____ float _____

Constipation? _____Blood in stool? _____Mucus in stool? _____Pain when stooling? _____

Other concerns: _____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself? _____

If possible, please describe the most negative emotion you experience_____

When do you most often feel this emotion: _____Where are you? _____

Do you pray to or have a spiritual practice_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself:

Faith_____Hope_____Charity_____Generosity_____ Sense of Humor_____

Sense of Fun _____Fear _____Grief _____ Other (describe briefly) _____

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment? _____

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months: _____

One Year: _____

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other: _____Length of time using method_____

Reproductive Health History
Female Anatomy

Last Pap smear _____ Results (if known) _____

Are you under the treatment for Infertility _____Describe current treatment to date: _____

(IUI, IVF, etc.)_____

Gynecological Provider: _____Address_____Phone_____

Menstrual History Review and check as indicated:

Age of Menses: _____What was this like for you? _____

Last Menstrual Period: _____Length of Menses_____

Are you trying to conceive? _____Possibility of Pregnancy_____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?			

Pregnancy History:

Number of Pregnancies: **Number of Births:** **Dates:**	**Complications:**	**Miscarriages:**	**Terminations:**
Premature Births:	**Spotting during Pregnancy**	**Weak Newborns at Birth**	**Incompetent Cervix**

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing_____

Post-Partum: _____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis PMS Menopause

Cancer (type) _____Menstrual Problems _____ Other_____

Medications your mother took when she was pregnant with you (if any) _____

Your Birth Trauma (if known) _____

Other:

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Do you have a history of rape _____trauma _____incest ____If so,-when_____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information:

Menopause

Age symptoms began: _____ Are they getting worse _____better _____same _____

Are you on/ or ever been on hormone replacement therapy? _____if so, how long_____

Name and dose_____

Reason for stopping_____

Age of Mother at menopause: _____Concerns/Experience_____

Check the following symptoms that apply to you:

Hot flashes	**Insomnia**	**Fatigue**	**Memory Loss**	**Mood Swings**
Vaginal Discharge	**Dry Vagina**	**Depression**	**Anxiety**	**Irritability**
Spotting	**Flooding**	**Irregular Menses**	**Painful Intercourse**	**Increased Libido**
Decreased Libido	**Disturbed Sleep Pattern**			

Reproductive Health History
Male Anatomy

Please check the symptoms below that apply

Painful Urination	**Past Present**	**Urinary Retention**	**Past Present**
Urinary Incontinence or Dribbling		**Difficult starting or holding urine stream**	
Weak or Interrupted Urine flow		**Blood or pus in urine**	
Pain or Burning with Urination		**Pelvic pressure**	
Nocturnal Urination How many times?		**Insatiable sex drive**	
Pain in lower back, esp. After intercourse		**Pain or Discomfort Between scrotum and Testicles**	
Pain or Discomfort in: Penis Testicles Rectum		**Pain or Discomfort in Inner thighs: Left Right Both**	
Frequent Bladder or Kidney Infections When?		**Erection: Difficulty in Obtaining Maintaining Painful ejaculation**	

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known) _____Date done_____

Family History of Prostate Disease: Yes___No___Type_____Relationship_____

Family History of Cancer Yes____No_____Type_____Relationship_____

Sexually transmitted disease Yes ___No ___Type if Known_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have a history of rape _____trauma _____incest _____ If so, when? _____

Did you undergo counseling for this? _____

What was this like for you _____

FOR FEMALE AND MALE CLIENTS: Additional Information you feel important your practitioner should know that is not mentioned here: