



# INTAKE FORM

[www.naturalbalancetherapy.com](http://www.naturalbalancetherapy.com)

## PERSONAL INFORMATION: *(Please print clearly)*

Name: \_\_\_\_\_  
Last First Middle Initial

Home Address: \_\_\_\_\_  
Street City State Zip

Primary Telephone: ( ) \_\_\_\_\_ Home Work Cell

Secondary Telephone: ( ) \_\_\_\_\_ Home Work Cell

Date of Birth: \_\_\_\_\_ Sex: M / F Occupation: \_\_\_\_\_

Marital Status: S M W D Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ P: ( ) Relationship: \_\_\_\_\_

## MEDICAL INFORMATION:

Who referred you to our clinic: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

*Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.*

1. What is the primary complaint that brings you in for treatment today?

Secondary complaint?

As a result, I am now having difficulty with:

2. When and how did your symptom(s) begin? Date: \_\_\_\_\_

3. Have you ever received the following treatment for this condition?

	Yes	No	How Long?	Helpful?
Physical Therapy	_____	_____	_____	Yes No
Myofascial Release	_____	_____	_____	Yes No
Chiropractic	_____	_____	_____	Yes No
Other: _____	_____	_____	_____	Yes No

4. Past Medical History (include dates of occurrence)

Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

5. List ALL medications which you are currently taking (include supplements, herbal and homeopathic remedies). Please include reason for medication.

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6. Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or more frequently.

**MUSCULO-SKELETAL:**

_____	Headaches/migraines	_____
_____	Joint stiffness	_____
_____	Joint swelling	_____
_____	Spasms/cramps	_____
_____	Fractured bones	_____
_____	Strains/Sprains	_____
_____	Back/hip pain	_____
_____	Neck/shoulder pain	_____
_____	Arm/hand pain	_____
_____	Leg/foot pain	_____
_____	Jaw pain/TMJ	_____
_____	Tendonitis	_____
_____	Bursitis	_____
_____	Scoliosis	_____
_____	Arthritis	_____
_____	Osteoporosis	_____

**CIRCULATORY/RESPIRATORY:**

_____	Dizziness	_____
_____	Shortness of breath	_____
_____	Chest pain/tightness	_____
_____	Heart disease	_____
_____	Varicose Veins	_____
_____	Fainting	_____
_____	Cold feet/hands	_____
_____	Lymphedema	_____
_____	Excessing sweating	_____
_____	Sweaty palms	_____
_____	Blood clots	_____
_____	Allergies	_____
_____	Sinus condition	_____
_____	Asthma	_____
_____	Hi/Lo blood pressure	_____
_____	Diabetes	_____

**DIGESTIVE/URINARY:**

_____	Indigestion	_____
_____	Constipation	_____
_____	Diarrhea	_____
_____	Bowel irregularity	_____
_____	Liver Disease	_____
_____	Bloating/gas	_____
_____	Heartburn	_____
_____	Stomach cramps	_____
_____	Nausea/vomiting	_____
_____	Painful urination	_____
_____	Frequent urination	_____
_____	Urgent urination	_____
_____	Incomplete urination	_____
_____	Unable to hold urine	_____
_____	Kidney disease	_____

**REPRODUCTIVE:**

_____	Currently pregnant	_____
_____	Previous pregnancies	_____
_____	# pregnancies	_____
_____	# live births	_____
_____	# premature births	_____
_____	Periods	_____
_____	Irregular periods	_____
_____	Painful periods	_____
_____	PMS	_____
_____	Endometriosis	_____
_____	Menopause	_____
_____	Hot flashes	_____
_____	Breast lump/tender	_____
_____	Hysterectomy	_____
_____	Prostate condition	_____
_____	Impotence	_____

**NERVOUS SYSTEM:**

_____	Numbness/tingling	_____
_____	Twitching of face	_____
_____	Fatigue	_____
_____	Tired during day	_____
_____	Extreme fatigue	_____
_____	Chronic pain	_____
_____	Sleep Disorders	_____
_____	Epilepsy/Seizures	_____
_____	Stroke	_____
_____	Ulcers	_____
_____	Paralysis	_____

**MISCELLANEOUS:**

_____	Loss of appetite	_____
_____	Coughing	_____
_____	Stuffy nose, congestion	_____
_____	Vertigo/earache	_____
_____	Sore throat	_____
_____	Forgetfulness	_____
_____	Confusion	_____
_____	Hearing impaired	_____
_____	Difficulty concentrating	_____
_____	Visually impaired	_____
_____	Eyestrain	_____

**M = MONTHLY**

**W = WEEKLY**

\_\_\_\_\_ Herpes/shingles \_\_\_\_\_  
 \_\_\_\_\_ Cerebral palsy \_\_\_\_\_  
 \_\_\_\_\_ Chronic fatigue synd. \_\_\_\_\_  
 \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_  
 \_\_\_\_\_ Muscular dystrophy \_\_\_\_\_  
 \_\_\_\_\_ Parkinson's disease \_\_\_\_\_  
 \_\_\_\_\_ Spinal cord injury \_\_\_\_\_

\_\_\_\_\_ Blurry vision \_\_\_\_\_  
 \_\_\_\_\_ Eye irritation \_\_\_\_\_  
 \_\_\_\_\_ Eating disorder \_\_\_\_\_  
 \_\_\_\_\_ Fibromyalgia \_\_\_\_\_  
 \_\_\_\_\_ Cancer \_\_\_\_\_  
 \_\_\_\_\_ Infectious Disease \_\_\_\_\_  
 \_\_\_\_\_ Rashes \_\_\_\_\_  
 \_\_\_\_\_ Athlete's foot \_\_\_\_\_  
 \_\_\_\_\_ Metal Implants \_\_\_\_\_  
 \_\_\_\_\_ Alcohol use \_\_\_\_\_  
 \_\_\_\_\_ Nicotine use \_\_\_\_\_  
 \_\_\_\_\_ Caffeine use \_\_\_\_\_  
 \_\_\_\_\_ Uninterested in sex \_\_\_\_\_  
 \_\_\_\_\_ Unable to enjoy sex \_\_\_\_\_  
 \_\_\_\_\_ Water retention \_\_\_\_\_

**PSYCHOLOGICAL:**

\_\_\_\_\_ Unable to cope \_\_\_\_\_  
 \_\_\_\_\_ Easily annoyed/irritated \_\_\_\_\_  
 \_\_\_\_\_ Depression \_\_\_\_\_  
 \_\_\_\_\_ Anxiety \_\_\_\_\_  
 \_\_\_\_\_ Difficulty with family \_\_\_\_\_  
 \_\_\_\_\_ Difficulty with friends \_\_\_\_\_  
 \_\_\_\_\_ Worrisome thoughts \_\_\_\_\_  
 \_\_\_\_\_ Recurring bad thoughts \_\_\_\_\_  
 \_\_\_\_\_ Thoughts of suicide \_\_\_\_\_  
 \_\_\_\_\_ Fearful of people/places \_\_\_\_\_

7. If sleep is a problem, answer these questions:

Do you have trouble falling asleep? Yes No  
 Is your sleep restful? Yes No  
 How many times do you wake in the night? \_\_\_\_\_  
 How long before you fall back to sleep \_\_\_\_\_

8. Do you engage in regular exercise? Yes No

What type and how often? \_\_\_\_\_

Are you able to exercise now? Yes No

Do you have discomfort, shortness of breath, or pain with exercise? \_\_\_\_\_

9. In general, your lifestyle is:      1      2      3      4      5  
   Active      Average      Inactive

10. Patient Goals: List the activities that you would like to be able to do as a result of therapy.

	Activity	Duration/How Often	By When
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
	Other Goals? _____		

I have stated all medical conditions to the best of my knowledge and will update the therapist of any changes in my health status.

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_