

INTAKE FORM

Initial Appointment Date_____

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work (_____)_____

Cell (_____)_____

E-mail (office use only)_____ Fax (_____)_____

Local Contact Information (if different)_____

Occupation_____

Date of Birth _____ Height_____ Weight_____

Sex _____

Marital Status: Single Married Partnered Divorced Separated Widow(er)

Spouse/Partner Name (if applicable) _____

Who referred you? _____

A note on Health Insurance

I do not take health insurance for my services but many of my clients get reimbursed by their health insurance companies for them.

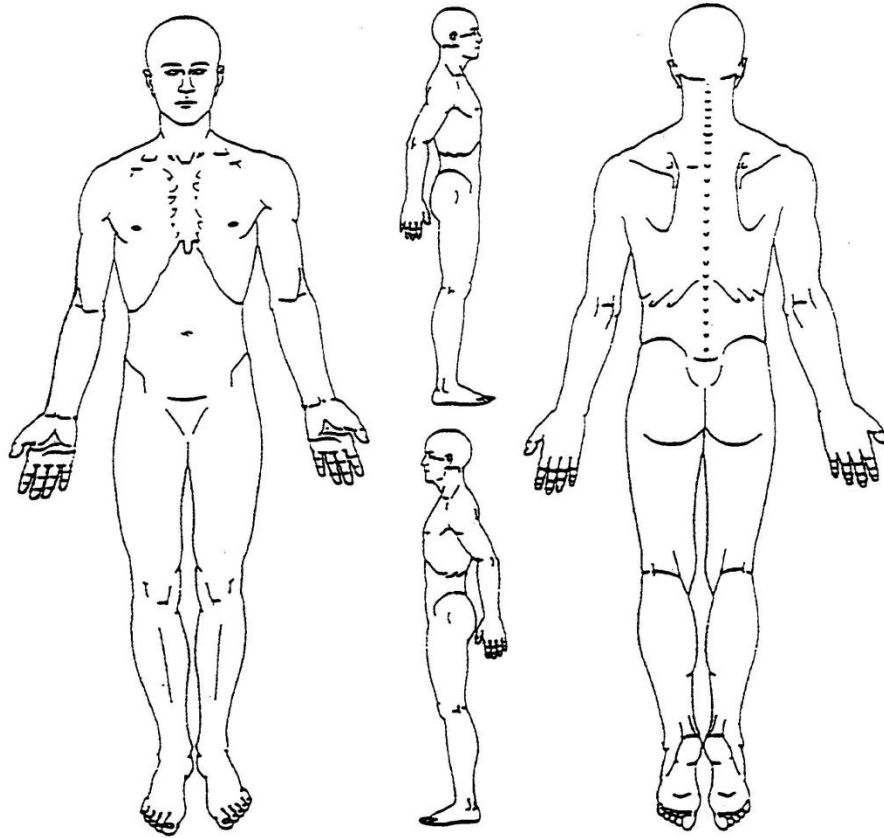
*Whenever possible, get a referral from your physician for **manual therapy** or **massage therapy**, this will increase your chances to get reimbursed. Your physician is also kept informed about your progress with appropriate reports.*

Please make sure to speak with your Health Insurance provider to find out the details and address your questions.

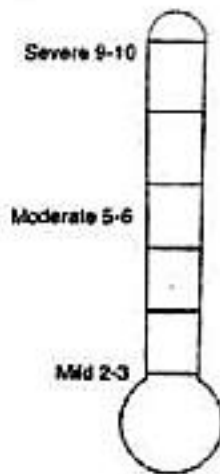
Please give a 48 hour cancellation notice if you can not make an appointment at (206) 605-3949

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Where exactly is the problem? Outline your discomfort in red



Rate the recent level of pain by shading in the thermometer below.



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Has it been getting *BETTER* or *WORSE*? (Circle one)

Describe how it feels: (*aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating - if so where?*)

How did it start the first time and this time, if this is not the first? (*Sudden or gradual onset and mechanism of injury*)

How often does it bother you?

- Constant all the time Everyday
 _____x per week _____x per month

How long does it last once it is there?

- Always there _____ minutes/hours No pattern

What specifically makes it worse?

- Certain movements/activities Stress
 Time of day No pattern

What makes it feel better?

- Certain movements/activities Heat/ice No pattern
 Time of day Therapies Nothing

Do you have a diagnosis from a Doctor? If, yes please list it.

Other therapies/remedies tried and results:

Have you ever had any surgeries and were they beneficial at the time?

List any other health problems for which you are being treated:

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Do you have any preexisting conditions that relate to this present injury?

Yes

No

If yes, please explain:

What do you believe caused or is causing this condition?

What are your goals for your health and your well being?

General Medical History

- Arthritis
- Allergies
- Asthma
- Autoimmune Disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal Tunnel syndrome
- Circulatory problems
- Colitis
- Dental Problems
- Diabetes
- Diverticular Disease
- Drug addiction
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Fibromyalgia
- Food intolerance
- GERD
- Glaucoma
- Gout
- Heart Disease
- Infection, chronic
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome

- Kidney or Bladder Disease
- Liver or gallbladder disease (stones)
- Migraine Headaches
- Neurological problems (paralysis, Parkinson's)
- Stroke
- Thyroid trouble
- Osteoporosis
- Pneumonia
- Ulcer
- Urinary Tract Infection
- Varicose Veins
- Other

Health Habits

- Tobacco
- Cigarettes # /day
- Cigars #/day
- Alcohol
- Wine: # glasses/ d or wk
- Beer: # glasses/ d or wk
- Liquor: # ounces/ d or wk
- Coffee: # 6 oz cups/ d
- Tea: # 6 oz cups/ d
- Soda w. Caffeine: # cans/ d
- Other Sources
- Water: # glasses/ d

Current Supplements

- Multivitamins
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/ GIA
- Calcium, source
- Magnesium
- Zinc
- Minerals, describe
- Friendly Flora (acidophilus)
- Digestive Enzymes
- Amino Acids
- CoQ10
- Antioxidants (e.g. lutein, resveratrol, etc.)
- Herbs (teas)
- Herbs-extracts
- Chinese Herbs
- Ayurvedic herbs
- Homeopathy
- Bach Flowers
- Protein Shakes
- Super-foods (e.g. bee pollen,
- Phylonutrient blends
- Liquid Meals (e.g. Ensure)
- Other: