Phoenix Healing Arts

Confidential Health Intake Form

Name _____

Date of Birth _____

Street Address/Apt Number

_____

City_____ State_____ Zip_____

Your Best Contact Phone Number_____

Your best email for contact _____

Emergency Contact name & number_____

Occupation/employer

_____

Primary Physician: _____

Phone number: _____

I understand the benefits and risks of integrated manual & energetic bodywork and give my consent for it. I will consult my practitioner with any questions or concerns immediately. I also understand that trauma release techniques are not a replacement for psychotherapy.
I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee

Signature _____

Date _____

Name_____ Today's Date_____

Phoenix Healing Arts

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___fibromyalgia
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___ depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems

Women only: ___Pregnant ___ Painful menstruation

Men only: ___Prostrate problems

If you experience chronic pain, please state where and why, as well as duration.

_____

_____

List all medications/herbs/vitamins and dosage:

_____

_____

_____

_____

_____

List physical activities you participate in

regularly_____ How often?_____

Are any movements or activities limited?

_____

Describe the reason you have come today:

_____

_____

List previous major injuries/surgeries:

_____

_____

Name_____ Today's Date_____

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_____

Are you receiving any other treatments and by who (acupuncture, physical therapy, chiropractic, naturopathic):

_____

_____

_____

What seems to help the most?

_____

What seems to aggravate your condition the most?_____

What is your main activity at work? On phone _____ Sitting_____

Computer work_____ Driving car_____ Walking_____

Other describe_____

What do you do to relieve stress?_____

What do you want to get out of you session(s)?_____

_____

Is there anything else you think I need to know?_____

_____

_____

_____

_____

_____

Practitioner

Comments_____

_____

_____

_____

Name_____ Today's Date_____

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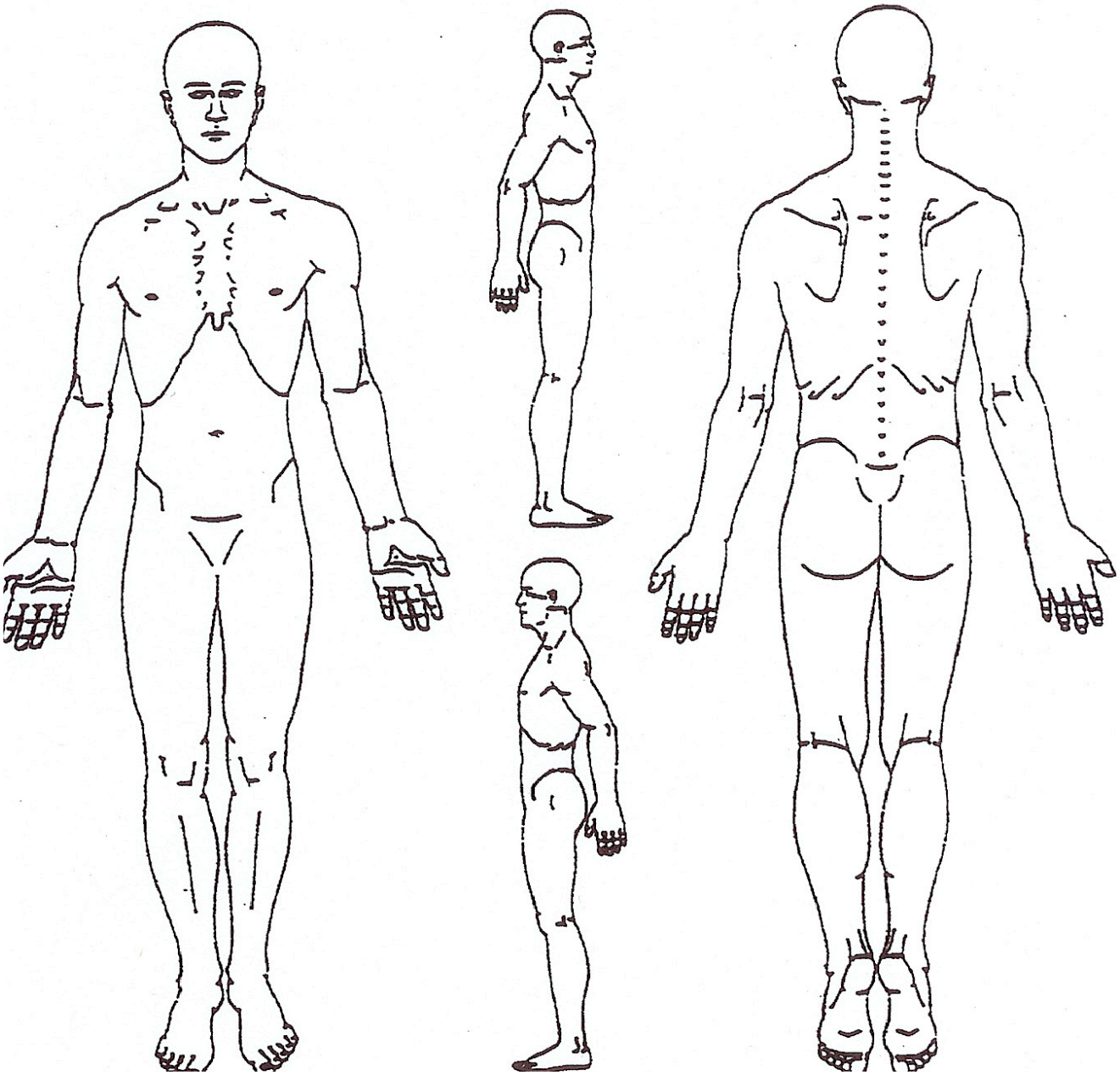
Please put an X where you feel pain, and an O where you feel tightness or numbness



Name_____ Today's Date_____