Integrative Healing Treatment Intake Form

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ATMAT® & Craniosacral

Confidential Intake Form

Date of initial visit ____.____.____

Name _____ Pronoun _____

Legal Name (if different from above)

_____

Address _____

Preferred phone number _____

Email _____ Date of birth _____

Occupation _____

Emergency contact name and phone number

_____

How did you find me? _____

Client Confidentiality and Release Form

I, (name)_____, give my permission for this practitioner to take notes including health history/medical and/or personal information I choose to disclose to her and that this information will be treated as confidential. Furthermore, I understand that massage/bodywork should not be construed as a substitute for medical care. I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment.

Client Signature _____ Date: _____

Practitioner Signature _____ Date:_____

A parent or legal guardian must give informed written consent for any client under age 18.

Reasons for Visit

Primary reason for visit _____

When did you first notice it? _____

Are there any causes or patterns you noticed? _____

_____

Was there an emotional, spiritual or physical event(s) that occurred around the onset?

_____

_____

Are there activities that provide relief? _____

Are there activities that make it worse? _____

Is this condition worsening? _____

Does it interfere with work? _____ Sleep? _____ Recreation? _____

Have you had massage/bodywork before? _____

If so, when and what type? _____

Medical History

Are you under the care of another health care practitioner(s)? Yes No

Reasons(s) _____

_____

Name of practitioner(s) _____

Practitioner's phone _____ Email _____

Current medications and/or supplements/remedies

_____

_____

Please specify any medicinal allergies, sensitivities and adverse reactions

_____

Surgical history (year and type) and/or recent procedures
_____

_____

Hospitalizations _____

Accidents or traumas (car accident, joblessness, death of a loved one, sexual assault, etc.) _____

_____

Please describe any falls and/or injuries to the head, sacrum or tailbone
____

_____

Please circle any symptoms that apply to you, and mark whether they are "Past" or "Present." Please fill in any relevant blanks.

Asthma
Past ___ Present ___

Cancer
Type:_____
Past ___ Present ___

Cold hands or feet
Past ___ Present ___

Contact lenses
Past ___ Present ___

Dentures/partials
Past ___ Present ___

Difficulty falling asleep, staying awake or waking up
Past ___ Present ___

Fainting spells
Past ___ Present ___

Feeling down, less interest in usual activities, differences in sleep or appetite
Past ___ Present ___

Headaches
Type: _____
Past ___ Present ___

Hemorrhoids
Past ___ Present ___

Herniated/bulging discs
Past ___ Present ___

High or low blood pressure
Past ___ Present ___

Low back pain
Past ___ Present ___

Muscular tension
Location: _____
Past ___ Present ___

Numbness in feet or legs when standing
Past ___ Present ___

Prosthesis or artificial limb(s)
Past ___ Present ___

Sciatica
Past ___ Present ___

Seizures
Past ___ Present ___

Sinus conditions, frequent colds
Past ___ Present ___

Skin ailments
Past ___ Present ___

Sleep disturbance
Past ___ Present ___

Sore heels when walking
Past ___ Present ___

Swollen ankles
Past ___ Present ___

Varicose veins
Past ___ Present ___

Worry, restlessness
Past ___ Present ___

Digestion and Elimination

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____ Water intake (8oz glasses/day) _____

Please circle "Yes," "Sometimes" or "No" for the following.

Caffeine: Yes Sometimes No If so, how often and what quantity? _____

Tobacco: Yes Sometimes No If so, how often and what quantity? _____

Alcohol: Yes Sometimes No If so, how often and what quantity? _____ Marijuana: Yes Sometimes No If so, how often and what quantity? _____

How often are your bowel movements? _____

Sexual and Reproductive Health

If any questions feel irrelevant, please feel free to skip them.

Method of contraception: (Please circle none or multiple.)
Abstinence Condoms Diaphragm Fertility Awareness Injection IUD Patch Pills Rhythm method Other

Length of time using method _____

Date of last Pap smear _____

Results of last Pap smear _____

Are you seeking support around fertility? _____

Are you currently actively trying to conceive? _____

Please describe current support to date (IUI, IVF, etc.). _____

_____

_____

Menstrual History

Age of first menstruation _____ What was this like for you? _____

_____

Date of last menstrual period _____ Length of menstrual cycle _____

Check all that apply indicating "past" or "present," and "location" if relevant.

Bladder

☐ Cysts
Location _____
Past ___ Present ___

☐ Nocturnal urination
How many times per night?
Past ___ Present ___

☐ Pain or burning with urination
Past ___ Present ___

☐ Urinary incontinence/dribbling
Past ___ Present ___

☐ Urinary infection
Past ___ Present ___

☐ Water retention
Past ___ Present ___

☐ Weak or interrupted urine flow
Past ___ Present ___

Ovaries

☐ Bloating
Location _____
Past ___ Present ___

☐ Cysts
Location _____
Past ___ Present ___

☐ Painful ovulation or lack of ovulation
Location _____
Past ___ Present ___

Penis

☐ Cysts
Location _____
Past ___ Present ___

Rectum

☐ Cysts
Location _____
Past ___ Present ___

Prostate

☐ Cysts
Location _____
Past ___ Present ___

Testicles

☐ Cysts
Location _____
Past ___ Present ___

Uterus

☐ Bloating
Past ___ Present ___

☐ Cysts
Location _____
Past ___ Present ___

☐ Dark thick blood at Menstruation
Beginning ___ End ___
Past ___ Present ___

☐ Endometriosis
Location, if known ___
Past ___ Present ___

☐ Excessive bleeding
Pads per hour _____
Past ___ Present ___

☐ Fibroids
Location, if known ___
Past ___ Present ___

☐ Headaches or migraines with menstruation

Past ___ Present ___

☐ Heaviness in pelvis prior to menstruation
Past ___ Present ___

☐ Irregular cycles
Early ___ Late ___
Past ___ Present ___

☐ Painful intercourse
Past ___ Present ___

☐ Painful periods
Past ___ Present ___

☐ Skipped menstrual cycle
How long? _____
Past ___ Present ___

☐ Uterine or cervical polyps
Past ___ Present ___

☐ Uterine infections
Past ___ Present ___

☐ Vaginal dryness
Past ___ Present ___

☐ Vaginal infections
Past ___ Present ___

Pregnancy History

Are you currently pregnant? Yes No • If Yes, how many weeks?
_____

Have you been pregnant before? Yes No

If so, how many pregnancies? _____ How many births? _____

Please list the birth dates _____

Were any of the births premature? Yes No Did you have any complications in any pregnancy?
_____

Please circle what (if any) complications apply to you.

Spotting during pregnancy Weak newborns at birth Challenged cervix

Premature births Miscarriages Terminations Other complications

Briefly describe experiences with:

Pregnancy _____

Labor _____

Birthing _____

Postpartum _____

Maternal Family of Origin History: *Please circle what applies to you.*

Fertility challenges Fibroids Endometriosis PMS

Menopause Cancer Menstrual challenges Other

Were there any medications your parent took when pregnant with you? _____ If so, what were they? _____

Are you aware of any negative events or emotions related to your birth? ____

Please explain. _____

_____

Indicate your interest in sex. High ____ Moderate ____ Low ____ None _____

Do you have or have you ever had difficulty experiencing orgasms? _____

_____

Have you experienced the following? Emotional abuse _____ Incest _____

Rape _____ Trauma _____ Violence _____

If so, how recently? _____

What support did you receive around your experience, if any? _____

_____

What impact does this currently have on your life? Please circle one.
None Some impact Every day Very impactful

Comments _____

_____

_____

Hormonal Changes/Menopause

Are you currently or have you ever have been on hormone therapy? _____

If so, for how long? _____ Name and dosage _____

Reason for stopping _____

If menopausal, age symptoms began _____

Please circle if the symptoms are getting: Worse Better Same

Age of mother at menopause _____ Concerns/experiences of the process

_____

Please check the symptoms that apply to you.

- ☐ Hot flashes
- ☐ Insomnia
- ☐ Dry vagina
- ☐ Flooding
- ☐ Irregular menstrual cycles
- ☐ Vaginal discharge
- ☐ Spotting
- ☐ Increased/decreased libido
- ☐ Memory loss
- ☐ Fatigue
- ☐ Mood swings
- ☐ Painful intercourse
- ☐ Irritability
- ☐ Worry, restlessness
- ☐ Feeling down, less interest in usual activities, difference in sleep or appetite
- ☐ Difficulty falling asleep, staying awake, or waking up
- ☐ Weight gain
- ☐ Weight loss

On the following page, please share any additional information you feel is important that isn't mentioned above