ATMAT CONFIDENTIAL CLIENT INTAKE FORM

Name:_____**Date of Initial Visit**_____

Address_____**State**_____**Zip**_____

Home Phone_____**Work Phone**_____**email**_____

Date of Birth_____**Age**_____**Occupation**_____

Marital status_____**Referred by**_____

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

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

When did your first notice it?_____**What brought it on?**_____

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**_____

Describe your exercise routine (type, frequency)_____

FAMILY HISTORY

Alive? Age/Cause of Death Major Health Issues

Mother:_____

Father:_____

Siblings:_____

Maternal Grandmother_____

Maternal Grandfather_____

Paternal Grandmother_____

Paternal Grandfather_____

Family History of Abuse_____**circle if applicable : physical emotional sexual spiritual**

Family History of Substance Abuse_____**Suicide**_____ **Other Trauma**_____

DIGESTION & ELIMINATION

Typical Breakfast:_____

Typical Lunch:_____ **Typical Dinner:**_____

Snacks:_____ **Water Intake(glasses/day)**_____**Caffeine**_____

What is the worse thing on your diet_____ **Which 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_____

What changes would you like to achieve in 6 months_____**One Year**_____

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:_____

_____

Allergies: specify allergen and reaction:_____

Supplements/Remedies_____

_____

Do you use Tobacco?_____ Quantity_____Alcohol?_____Quantity_____ounces/ day

Marijuana?_____Quantity_____Other:

Have you been under treatment for substance use? If so, describe:_____

Surgical History (year and type)_____

_____

Recent Procedures:_____

Hospitalizations _____

_____

Accidents or Traumas_____

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

Birth Trauma if known _____

CIRCLE any of the following conditions you are experiencing NOW.
UNDERLINE any of the conditions you have experienced in the PAST.

Musculo-Skeletal
bone/joint disease
tendonitis
bursitis
arthritis
osteoporosis
muscle spasms/cramps
painful/swollen joints
headaches/ migraines
jaw pain/TMJ
neck , shoulder pain
chest pain
arm, hand pain
low back, hip pain
leg, foot pain
scoliosis
sciatica
spinal problems
other_____

Circulatory
heart condition
heart pain
high blood pressure
low blood pressure
diabetes
blood clots
phlebitis
cold hands/feet
swollen ankles or feet
lymphedema
varicose veins
fainting
other_____

Digestive
eating disorders s
constipation
gas/bloating
IBS
diverticulitis
other_____

Nervous System
nerve compression
herniated/bulging disks
epilepsy/seizures
tinnitus (ringing in ears)
fatigue
numb hands/feet
pins & needles arms, hands, legs, feet
loss of smell or taste
other_____

Infectious Diseases
hepatitis_____
HIV
other_____

Respiratory
asthma
lung/breathing problems
respiratory allergies
sinus conditions
other_____

Skin
skin allergies
rashes
athletes foot
warts
psoriasis
acne
fungus
other_____

Other
anxiety fatigue
trouble sleeping
loss of memory
contact lenses
dentures
depression
kidney problems
cancer/tumors
drug/alcohol addiction
nicotine/caffeine addition
artificial /missing limbs
headaches

List any additional medical information which you feel is important for your therapist to know. ___

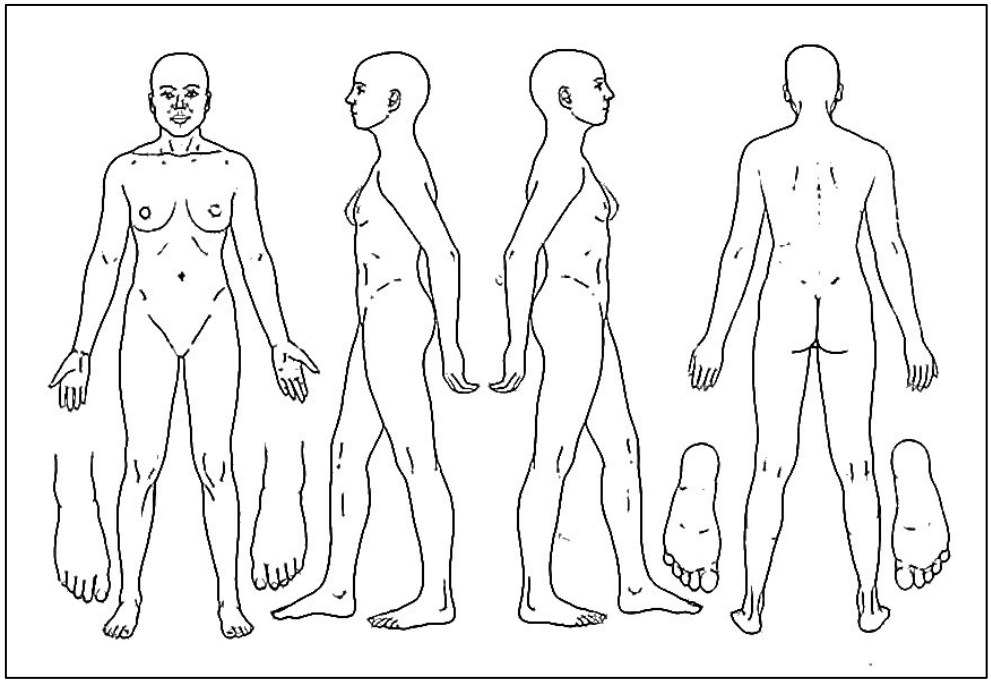
_____

_____

_____

_____

Mark any areas of current persistent pain or tension on the figures below:



FEMALE REPRODUCTIVE HEALTH HISTORY

Age of Menarche_____What was this like for you_____

How many Pregnancie(s) have you had?_____Number of Deliverie(s)_____Dates_____

Termination(s)_____When_____

Miscarriage(s)?_____When_____

Complications_____

What was your experience of: Pregnancy_____

Labor_____

Delivery_____

Post Partum_____

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

Maternal Family History of (please circle)

Infertility Fibroids Endometriosis------Cancer (type)_____

Menstrual Problems Menopause PMS

Method of Contraception (circle)

pills patch diaphragm injection condoms IUD abstinence rhythm method

Other:_____

Length of time on synthetic contraception (Pill, Patch or Injection):_____

Last Pap smear_____Results (if known)_____

Date of Last Menstrual period_____ Length of Menses_____

Episodes of Amenorrhea_____When_____For how long_____

Please circle as appropriate:

Painful periods Irregular (late or early) Dark Thick Blood at Beginning or End of Cycle

Dizziness with period Headache or Migraine with period Excessive Bleeding (> one pad/hour)

PMS/Depression with or before period Failure to Ovulate Painful Ovulation

Bloating/water retention with period Heaviness or pressure in lower pelvis with period

Other Symptoms (Circle and Describe as indicated)

Varicose veins of leg Tired weak legs Numb legs and feet when standing still

Sore heels when walking Low back ache Painful intercourse Constipation Endometriosis

Endometritis Uterine Polyps

Fibroids (Size and Location if known)_____

Uterine infections Frequent urination Bladder infections

Vaginal discharge (describe) _____ Vaginitis Vaginal Yeast infections

Chronic miscarriages Premature deliveries Weak newborn infants Difficult pregnancy

Incompetent cervix Spotting with pregnancy Pelvic Inflammation

Sexually Transmitted Disease (date and type)_____ Dry vagina (without menopause) Difficult menopause

Cancer (cervix, bladder, uterus, ovarian, bladder, bowel) Cysts (ovarian breast)

Are you under the treatment for Infertility_____

Describe current treatment to Date:_____

Gynecological Provider:_____

Address_____Phone_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest__If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

MENOPAUSE (Circle the symptoms that apply to you)

Hot flashes Insomnia Fatigue Memory Loss

Mood swings Irritability Vaginal discharge (describe):

Dry Vagina Fatigue Depression Spotting (menses)

Flooding Clotting Irregular menses Increased/Decreased Libido

Other symptoms not listed above_____

_____

When did these symptoms begin:_____

Are they getting worse_____better_____same_____Last Menstrual period_____

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

Name and dose_____

Reason for stopping_____

Other medications/herbal remedies_____

Age of Mother at menopause:_____Concerns/Experience_____

Additional Comments:

MALE REPRODUCTIVE HEALTH HISTORY

Circle and Describe those symptoms as applicable

Headaches: Migraine_____Tension_____Cluster_____

Low back pain Sore heels Varicose Veins: Location_____

Numbness in legs/feet Depression Anxiety Irritability

Family History of Prostate Disease:_____Type_____Relationship_____

Family History of Cancer_____Type_____Relationship_____

History of sexually transmitted disease_____When_____Type_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest__If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

Urinary Symptoms (circle those applicable)

Painful urination Bladder/Kidney infections

Frequent Urination Nocturnal Urination/ Frequency_____

Changes in urinary stream (describe flow, stream, strength of stream)_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Erectile Function (describe as indicated)

Difficulty maintaining an erection_____

Painful ejaculation _____

Is there a history of back injury/trauma_____Describe:_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Current Medications or Supplements:_____

_____

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

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

Additional Comments: