GROUNDSWELL MFR

INTAKE FORM

Today's date: _____

Patient's name: (print)_____ (signature)_____

(initials)_____ Date of birth: _____ Age: _____

If patient/client is under 18 years of age, Parent/Guardian's name: (print)_____

(signature)_____ (initials)_____

Address: _____

Mobile Phone: _____

Home Phone: _____

Work Phone _____

Email: _____

Height: _____

Weight: _____

Sex (please circle): Male Female

Marital status (please circle): Single Married Divorced Widowed

Physician(s): _____

How did you hear about us? _____

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HISTORY

Do you have any of the following medical conditions? (circle)

Circulatory problems	Y	N
High blood pressure	Y	N
Heart trouble	Y	N
Pacemaker	Y	N
Epilepsy	Y	N
Diabetes	Y	N
Pregnancy	Y	N
Stroke	Y	N
Blackouts	Y	N
Visual disturbances	Y	N
Recent or rapid weight changes	Y	N
Headaches	Y	N
Ringing in the ears	Y	N
Bowel / bladder problems	Y	N
Malignancy	Y	N
Other (please specify)	Y	N _____

_____

Past Medical History: Please list any and all diagnoses, conditions, traumas, or accidents (from birth to present, and year of occurrence)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social or Family History that may influence your current state:

_____

_____

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Medications: (Please indicate below current, then past medications, supplements, herbs)

Medication	For the Treatment of	Dose and Frequency	Effectiveness

Please mark any and all of the following symptoms which apply to you (past or present)

Symptom	Daily	Weekly	Yearly	Description
Headache				
Heart pounding or racing				
Irregular heartbeat				
Chest pain, tightness				
Numbness, tingling in arm or leg				
Can't keep warm enough				
Sweaty palms				
Blushing, flushing face				
Coughing				
Stuffy nose, congestion				
Earache or ringing noise in ears				
Common colds				

Symptom	Daily	Weekly	Yearly	Description
Sore throat				
Asthma or shortness of breath				
Hay fever or allergies				
Sore, aching muscles				
Stiff or tender joints				
Back problems				
Trembling or twitching muscles				
Skin rashes, eruptions				
Grinding of teeth (TMJ)				
Dry mouth				
Mouth sores				
Excessive perspiration				
Difficulty sleeping through the night				
Excessive drowsiness during day				
Periods of extreme fatigue				
Feeling faint or dizzy				
Feeling tense or nervous				
Difficulties with family or friends				
Worrisome thoughts				
Recurring bad thoughts				
Thoughts of suicide				
Fearful of persons or places				
Feeling inadequate/unable to cope				
Feeling guilty or failure				
Uncontrolled crying or sadness				
Easily annoyed or irritated				
Free-floating anxiety about life				
Voice quivering, shaking				
Eyes irritated or inflamed				
Vision blurred				

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Symptom	Daily	Weekly	Yearly	Description
Eyestrain or discomfort				
Nosebleeds				
Stomach cramps				
Heartburn or indigestion				
Nausea or vomiting				
Frequent urination				
Incomplete urination				
Painful urination				
Urinary leakage				
Bowel leakage				
Gas in lower bowel				
Diarrhea				
Constipation				
Bowel irregularity				
Uninterested in sexual relations				
Unable to participate in sex acts				
Menstrual difficulties				
Breast tenderness				
Hot flashes				
Water retention				
Over-eating, bingeing				
Lack of appetite				
Excessive alcohol abuse				
Other substance abuse				
Frequent laxative use				
Other:				

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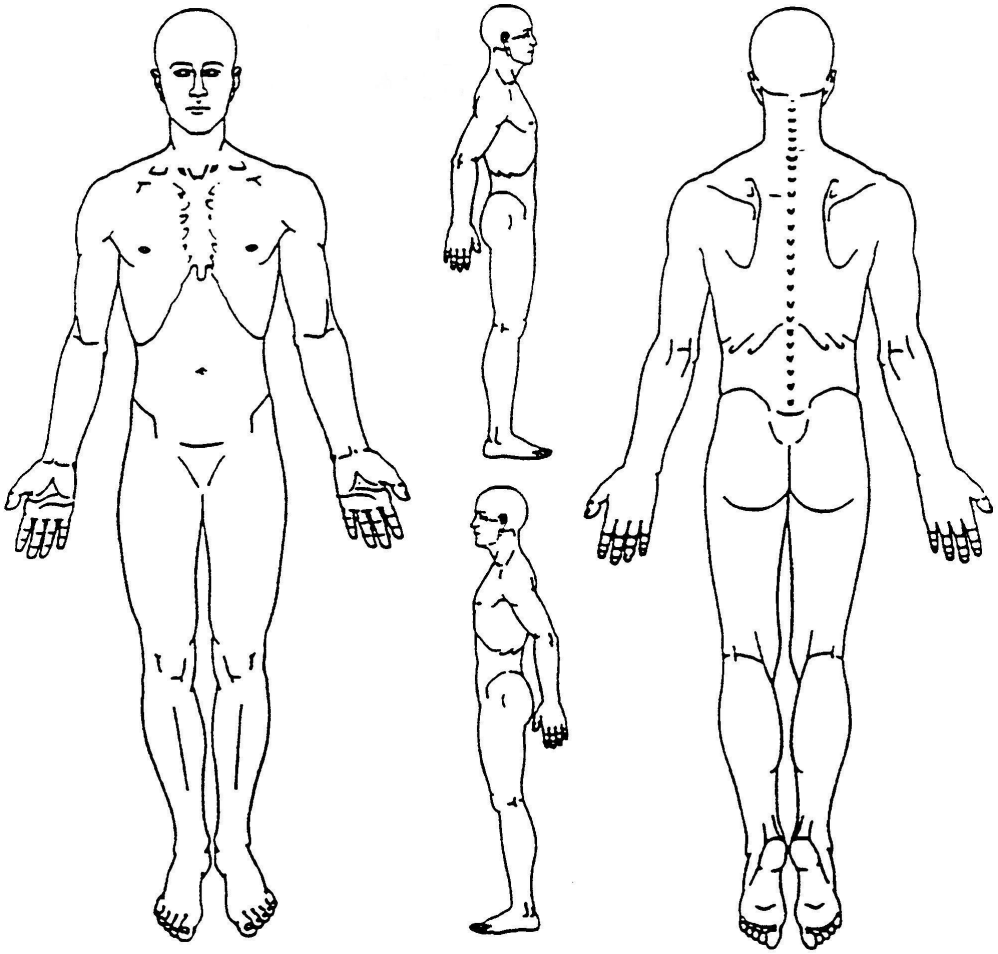
Please indicate the location, intensity and quality of your symptom(s):



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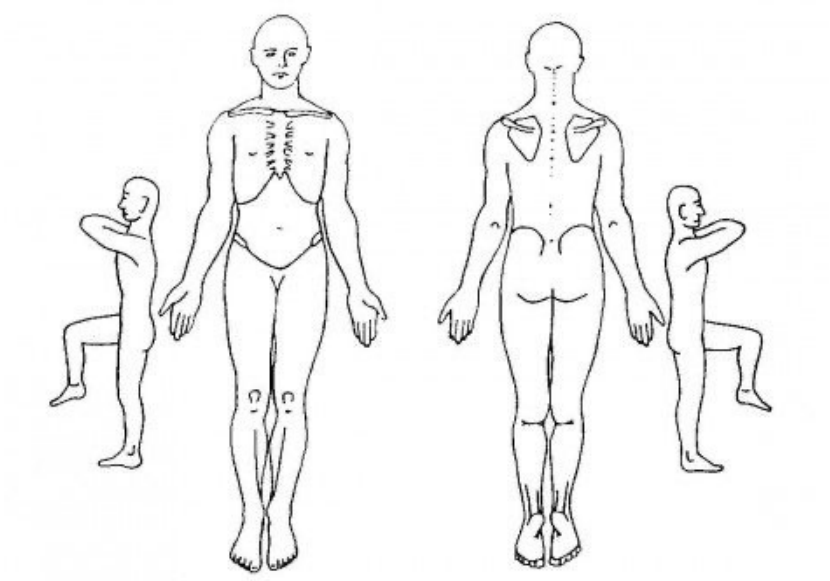

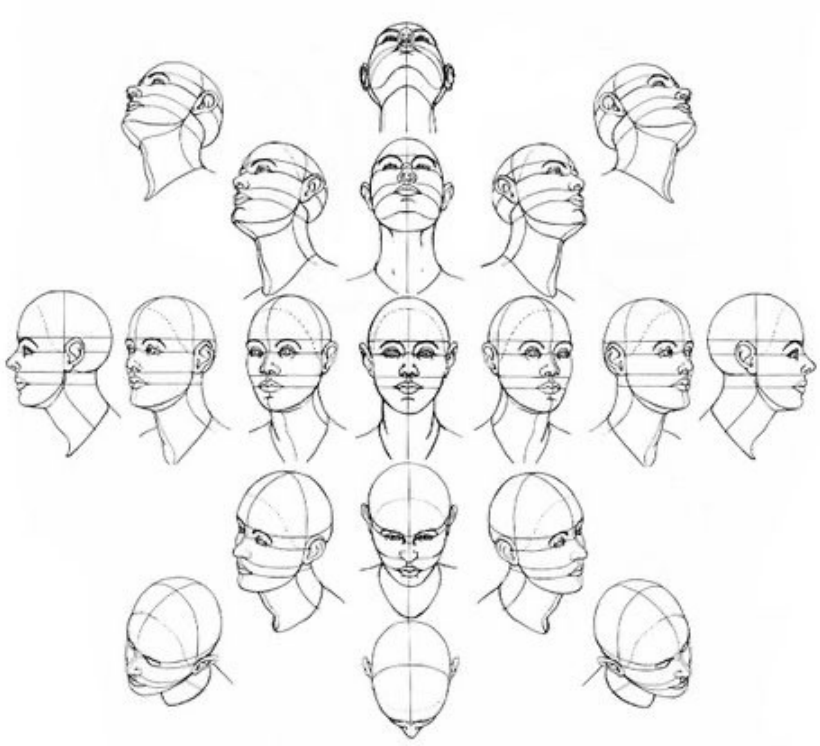

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What is or are your goal(s)/hope(s) for this treatment?

…as related to your family role(s)?

…as related to your work/profession/occupational role(s)?

…as related to your social role(s)?

What do you enjoy now?

What did you enjoy as a child?

What do you hope to enjoy?