

Footprints to Wellness, LLC.

Client Intake Form

Please complete the intake form as thoroughly as possible. All information is completely confidential and will greatly enhance the work we are able to accomplish together.

Name	Today's Date
Address	Email
City, State, Zip	Telephone
Date of Birth	Method of correspondence ___ email ___ mail ___ newsletter
Occupation	Where did you hear about me?
Emergency Contact (name & phone)	
Married ___ Separated ___ Divorced ___ Widowed ___ Single ___ Domestic Partner ___	
Live With: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___	

State the main reason for your visit today. Describe in detail any specific health condition. Include when it started and where, any associated symptoms, and any treatments used for the condition.

What else would you like to see changed in your health? (Indicate how long you have had each of these conditions)

How long has it been since you have been totally well?

List any healthcare professionals you are seeing (medical, therapists, counselors, chiropractors, etc).

List previous accidents or surgeries that you have had and include estimated dates.

Please list all medications you are currently taking, including aspirin, over the counter drugs, vitamins, herbs, etc.

Footprints to Wellness, LLC.

Client Intake Form

Please circle any of the following feelings you have experienced in the last few months.				Please circle the number that best describes the level of stress for the below listing. (1 being least 10 greatest)	
Abused	Paranoid	Unable to Grieve	Panic	My family stress is	1 2 3 4 5 6 7 8 9 10
Criticized	Overwhelmed	Apprehensive	Intolerant	My relationship stress is	1 2 3 4 5 6 7 8 9 10
Overworked	Muddled	Agitated	Uncertainty	My work stress is	1 2 3 4 5 6 7 8 9 10
Paralyzed	Persecuted	Uneasy	Aggravated	My financial stress is	1 2 3 4 5 6 7 8 9 10
Depressed	Guilty	Distress	Annoyed	My health stress is	1 2 3 4 5 6 7 8 9 10
Rejected	Easily Irritated	Fearful	Angry	Other stress is _____	1 2 3 4 5 6 7 8 9 10
Despair	Anxious	Impatient	Outraged	Quality of sleep	1 2 3 4 5 6 7 8 9 10
Helpless	Sad	Intimidated	Nervous	Quality of relaxation	1 2 3 4 5 6 7 8 9 10
Hopeless	Grieving	Restless	Worried	Level of physical exercise	1 2 3 4 5 6 7 8 9 10

Please list your main interests and hobbies.

Average 6-8 hrs. sleep?	Y	N	Enjoy work?	Y	N
Sleep well?	Y	N	Take vacations?	Y	N
Awaken rested?	Y	N	Spend time outside?	Y	N
Do you dream often?	Y	N	Meditate?	Y	N
Have supportive relationships?	Y	N	Do you exercise	Y	N
Have a history of abuse?	Y	N	What kind & how often? _____		
Any major traumas?	Y	N	Watch television?	Y	N
Do you eat three meals a day?	Y	N	How many hours per week? _____		
Do you eat out often?	Y	N	Spend time on the internet?	Y	N
Do you go on diets often?	Y	N	How many hours per week? _____		
Do you have pets?	Y	N	How many hours/week do you work? _____		

List 5 major events in your life (good or bad) from the most recent to the most distant.

1 _____

2 _____

3 _____

4 _____

5 _____

Which event has affected you the most and why?

Footprints to Wellness, LLC.

Client Intake Form

Describe your general state of physical and emotional health as a child.

Describe your general state of physical and emotional health as a teenager.

List any work-related or household environmental hazards or concerns.

Medical Conditions: If you have had any of the following indicate if it is a Current (C) or Past Condition (P).

Allergies	___	Diabetes	___	Hypertension	___	Pacemaker	___
Arthritis	___	Eating Disorder	___	Glaucoma	___	Pneumonia	___
Asthma	___	Emphysema	___	Gonorrhea	___	Seizures	___
Autoimmune	___	Heart Disease	___	Irritable Bowl	___	Stroke	___
Cancer	___	Hepatitis	___	Joint Problems	___	Syphilis	___
Chronic Fatigue	___	Herpes	___	Lung Disease	___	Ulcers	___
Chronic Infection	___	High Blood Press	___	Menopause	___	Venereal Disease	___
Depression/Anxi	___	HIV/AIDS	___	Osteoporosis	___	Weigh Changes	___

Family History:	Father	Mother	Siblings	Siblings	Siblings	Siblings
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good, avg.)	_____	_____	_____	_____	_____	_____
Deceased Age	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Indicate the number of relatives: grandparents, parents, brothers, or sisters who have or have had the following.

Alcohol/Drug Ab	___	Cancer	___	Hepatitis	___	Stroke	___
Arthritis	___	Depression	___	Heart Disease	___	Mental Illness	___
Autoimmune	___	Diabetes	___	Kidney Disease	___	Obesity	___
Alzheimer	___	Epilepsy/Seizure:	___	Stomach Disorde	___	Thyroid Conditio	___