Merkaba Center for Healing, LLC

Intake Form

Name ____ DOB______________
M / F / Other (specify): _________________________
Address____
E-mail ____
Phone:
(h)______________________(w)______________________(c)___________________
Occupation____
Sports/hobbies:____
Emergency contact ______________________ Referred by______________________

Please check all that apply (past or present):

__Abdominal / digestive problem: _______________

__Allergies / hay fever

__Arthritis (location): ________________________

__Asthma (explain): __________________________

__Ankle problem: _____________________________

__Back pain (location):________________________

__Bed wetting (children)

__ Birth Trauma: _____________________________

__Bone spurs (location):_______________________
__Breast lump (location):______________________
__Breast pain:_________________________________
__Breast implants (date):______________

__Bronchitis (how often):______________________
__Bunion (location): __________________________
__Bursitis (location):__________________________
__Buttock pain
__Cancer (describe):___________________________
__Carpal tunnel syndrome (any intervention):______

__Chest pain (describe): _______________________

__Colic (baby)

__Constipation (how often): ____________________
__Diabetes (onset): ___________________________
__Diaphragm pain or tightness

__Diarrhea (how often): _______________________

__Dizziness (onset & how often):________________
__Ear or eye problem

__Edema, general
__Elbow pain (type): _____________

__Fatigue, chronic (onset): _____________________

__Fibromyalgia or polymyalgia (onset):___________

__Fibroids - (location): _______________

__Fracture/s- (location/s): ________________

____

__Fallen on tailbone / coccyx: __________________

__Gall bladder problem (surgery?): _____________

__Heating pad / ice pack usage

__Hammer toes

__Hamstring pain or tightness

__Headaches, how often: ______________________
__Heart problem (describe): ____________________
__Hernia (location): _________________

__Hip pain (describe): ________________________
__Hip replacement (procedure and date): _________

__Incontinence / bladder (adult onset):____________

__Infertility (explain):_________________________
__Jaw / TMJ problem (onset):__________________
__Joint replacement:__________________________
__Knee problem:_______________________
__Liver problem
__Lung problem (onset):____________________
__Migraines (describe):_______________________
__Numbness (location): _______________________
__Orthodontia, extensive
surgery:______________________

__Orthotics in shoes

__Osteoporosis

__Pain, other (location): _______________________

__Pelvic pain
__Plantar fasciitis or neuroma

__PMS or menopause

__Pregnancy: _________________
__Prostate problem
__Rib pain / subluxation: ____________________

__Sacral pain
__Sciatica (location): ________________
__Scoliosis
__Shin splints
__Shoulder problem (explain): __________________
__Sinus problem
__Sleep / energy problem

__Tinnitus
__Uterine or ovary problem

__Wrist or thumb pain (explain): ________________
__ Other: ________________________________

Please list all other accidents, injuries, surgeries and falls that might be relevant in any way; include dates of occurrence.

____

____

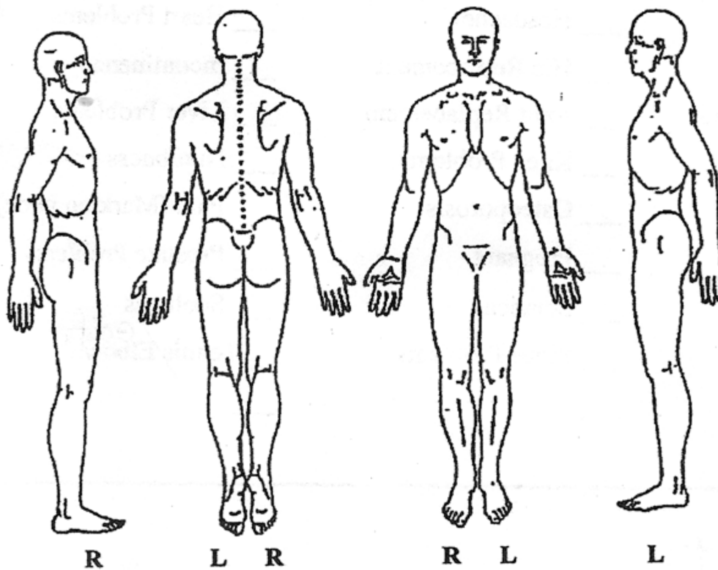
List activities compromised by condition(s):

____

Shade in the site(s) of pain on the anatomical drawing, and rate the severity of each pain on a scale of 1-10:

Pain intensity scale –

(2) Mild pain (annoying, nagging)
(4) Discomforting (troublesome, numbing)
(6) Distressing (miserable, agonizing, gnawing) (8) Intense (cramping, dreadful, horrible)
(10) Excruciating (tearing, crushing, unbearable)



Neck ROM:
L
R
TMJ:
Shoulder ROM:
L
R

Current medications (it is sufficient to state purpose, such as cholesterol, high blood pressure, osteoporosis):

____

____

Recent hands-on modalities received:

____

Prior to 18 years old, have you experienced any of the following? Place a check next to each statement that is true.

*** This information will be used to guide sessions accordingly.**

On a personal level:

Physical Abuse of any kind: ___

Mental/Emotional Abuse: ___

Verbal Abuse: ___

Substance Abuse: ___

In the Household:

Mental Illness: ___

Mother treated violently: ___

Sibling/s treated violently: ___

Divorce: ___

Incarcerated relative: ___

Death of a friend/loved one: ___

Substance Abuse: __

I have stated, to the best of my knowledge, my known medical conditions. I understand that Merkaba Center for Healing, LLC therapy intervention is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my practitioner of any changes in my condition and will contact my practitioner should I have any concerns.

Signature____Date________________

ALL INFORMATION IS HELD IN STRICT CONFIDENTIALITY