The Heart's Mission Creative Therapy

Suite 103 - 1037 W. Broadway Ave. Vancouver, BC V6H 1E3
604-704-3657 leah@theheartsmission.com

The intake form is to be filled out by all new clients.
The answers provided will become part of confidential health records.

INTAKE FORM • CLIENT INFORMATION

GENERAL DETAILS

First Name		**Goes By**			
Last Name		**Age**		**Birthday**	mm/dd/yyyy

How did you hear about us?	

CONTACT INFORMATION

Home Address		
City & Province		postal code
Home Phone	area code	
Cell Phone	area code	

Email Address	

By providing your email address, you are consenting to receive emails from The Heart's Mission Creative Therapy about upcoming promotions, monthly newsletters/blogs, special events and workshops. If at any time you wish to stop receiving emails, you may unsubscribe.

Emergency Contact		
Emergency Phone	area code	

OCCUPATION / LIFE MISSION WORK DETAILS

Current Occupation / Work Path	
Dream Work / Vocation / Occupation	
Most Favourite Things to Do	

GENERAL PRACTITIONER INFORMATION

Name of GP			
Date of Last Visit to GP	month	day	year
Reason for Last Visit			

Are you seeing a Medical Specialist?	YES	NO
Name of Specialist		
Reason for Seeing Specialist		

INTAKE FORM • CONFIDENTIAL HEALTH INFORMATION

HEALTH COMPLAINTS

Primary Health Complaint	
Other Health Complaints	
What would you like to gain from our visit? What are your two biggest health goals?	

MEDICAL HISTORY

Have you ever receieved care from a:	☐ Massage Therapist ☐ Chiropractor ☐ Psychologist ☐ Psychiatrist ☐ Acupuncturist ☐ Naturopath ☐ Craniosacral Therapist ☐ Energy Healing Therapist ☐ Physiotherapist Type: _____
Reason for your Visit	

Any recent:	
☐ X-Rays ☐ CT Scans ☐ MRIs	
Reason for This	

Please list any surgeries, hospitalizations, MVAs, or major accidents (with date)	
List any medications or vitamins/ supplements and the reason	

What is your overall stress level?	☐ Low ☐ Med. ☐ High
Reason(s) for stress?	

How often do you exercise?	
What types of exercise?	

Do you smoke?	YES	NO
How many per day?		
How long have you smoked for?		

FOR WOMEN ONLY			
Are you pregnant?	YES	NO	MAYBE
Do you have children?	YES		NO
If yes, by:	Natural Delivery		Caesarean Delivery

INTAKE FORM • REVIEW OF SYSTEMS

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form. If you are currently having any difficulty with the following, please check or mark the box. If you have a past history with any of the following that is no longer relevant to your current state of health please indicate a P in the box.

	GENERAL
	Insomnia
	Fatigue
	Weight Loss
	Weight Gain
	HEAD
	Headache
	Dizziness
	Head Trauma
	Fainting
	Blacking out
	EYES
	Itching/Redness
	Change in vision
	Cataracts
	Light Sensitivity
	Flashes in Vision
	Spots in Vision
	Glaucoma
	EARS
	Ringing/Tinnitus
	Impaired Hearing
	Earache
	Dizziness
	Discharge
	MOUTH & THROAT
	Bleeding Gums
	Cold Sores
	Sore Throat
	Jaw/TMJ Problems
	Hoarseness
	Swollen Glands
	Goiter
	NOSE
	Hayfever
	Loss of Smell
	Nosebleeds
	Sinus Problems

	LUNGS
	Difficulty Breathing
	Shortness of Breath
	Persistent Cough
	Coughing Phlegm
	Coughing Blood
	Asthma
	Pneumonia
	Emphysema
	Bronchitis
	Infections
	VASCULAR
	Angina
	Murmurs
	Heart Disease
	Chest Pain
	Palpitations
	Ankle Swelling
	Cold Feet/Hands
	Leg Cramps
	Calf Pain
	Varicose Veins
	Low Blood Pressure
	High Blood Pressure
	GASTRO-INTESTINAL
	Bloating/Gas
	Heartburn
	Ulcers
	Liver Disease
	Gall Bladder Disease
	Vomiting/Nausea
	Abdominal Pain
	Diarrhea
	Constipation
	Blood in Stool
	Hemorrhoids
	Hernias

	URINARY
	Difficulty Urinating
	Pain Urinating
	Blood in Urine
	Incontinence
	Bed-Wetting
	Urinary Urgency
	Frequent Urination
	Frequent Infections
	Kidney Stones
	NEUROLOGICAL
	Seizures/Epilepsy
	Strokes
	Tingling Sensation
	Numbness
	Muscle Weakness
	Difficulty Walking
	Poor Coordination
	Paralysis
	Speech Problems
	Loss of Memory
	MUSCLE & BONE
	Joint Pain
	Swollen Joints
	Stiffness
	Muscle Ache
	Foot Trouble
	Arthritis
	Bone Pain
	Fractures
	Dislocations
	SKIN
	Rash
	Itching/Hives
	Changes in Moles
	Acne
	Psoriasis
	Eczema

	ENDOCRINE
	Diabetes
	Hypoglycemia
	Hormone Therapy
	Thyroid Problems
	Heat/Cold Intolerance
	Excessive Thirst
	Excessive Hunger
	Excessive Sweating
	Night Sweats
	EMOTIONAL
	Depression
	Mood Swings
	Anxiety/Nervousness
	Tension
	Phobias
	Alcohol/Drug Abuse
	CONDITIONS
	AIDS/HIV
	Eating Disorders
	Heart Condition
	Rheumatic Arthritis
	Rheumatic Fever
	Alcoholism
	Cancer/Tumor
	Polio
	Parkinson's
	Multiple Sclerosis
	Gout
	Anemia
	Osteoporosis
	Osteoarthritis
	High Cholesterol
	Fibromyalgia
	Chronic Fatigue
	Hepatitis
	Migraines
	Contagious Blood Diseases

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INTAKE FORM • INFORMED CONSENT

Please read the following carefully and enquire if you have any questions or concerns.

Clients are required to agree to the following Release and Liability Waiver and Informed Consent and Authorization for Service, which is effective for all visits. Please note that Leah Hille and The Heart's Mission Creative Therapy do not diagnose conditions, prescribe medications or provide medical treatments.

Privacy Disclosure:

- All information you share is private and confidential.
- Your information will not be released to anyone without your written permission.
- If information is to be released, I will consult with you regarding what will be released.
- Your information will be kept in a secure location.

Exceptions to Privacy:

- Your confidential information may be released ***without your consent*** under the following conditions
- When there is apparent imminent risk of harm to the client or others from the actions of the Client.
- Under the law which mandates reporting for the protection against elder or child abuse.
- Under subpoena from a court of law.
- Additional exceptions may apply to minors and will be disclosed accordingly.

By signing below, I acknowledge and agree that:

- The sole purpose of this session/s is for relaxation or stress reduction, and in addition to balance, harmonize, release and heal on many levels including physical, mental, emotional and spiritual. I understand that the most profound changes occur with multiple sessions, however results are not guaranteed.
- I assume sole responsibility for my own health and for the results of any sessions provided by The Heart's Mission Creative Therapy that may affect my health in any way.
- Treatment/s will not replace conventional medical diagnosis or treatment. I will continue taking medication prescribed by a licensed medical physician and will continue to follow his/her instructions.
- I release Leah Hille and The Heart's Mission Creative Therapy, its owners and practitioners, from all legal liability during my participation in all/any of the following treatment/s, and I hereby consent to the performance of one or more of the following treatment/s: Aromatherapy Relaxation Massage, Craniosacral Therapy, Energy Healing, Reiki, Holistic Counselling, Art Therapy, Life Mission Coaching, The Way of the Heart™ Field Process Integrations and The The Way of the Heart™ Feng Shui Field Integrations.
- All information received by me from Leah Hille is accepted with full knowledge that any action taken by me as a result of the information received is my complete responsibility.
- Cancellations or missed appointments without a minimum or 24 hours' notice will incur a re-booking fee of $40

I have read the above statements carefully and have had the opportunity to ask questions about any concerns. By signing below I am signifying agreement to the above-mentioned conditions and procedures, and I accept services with full knowledge and understanding of relevant conditions. I intend this consent to apply to and cover the entire course of treatment(s) with Leah Hille and The Heart's Mission Creative Therapy.

Client Signature		***Client Name (please print)***	

Date Signed	month	day	year