

Spirit Dragon Healing Arts

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NEW CLIENT INTAKE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which phone # do you prefer to be contacted at? Cell \_\_\_\_ Home\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to contact you via email for post treatment check-ins, updates and specials? Yes \_\_\_ No \_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Committed relationship? Y/N

M/F Age: \_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or How did you hear about me? \_\_\_\_\_\_\_\_

MAJOR COMPLAINT:

What is your main reason for this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical conditions I should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications, herbs and supplements you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

Father: Alive/Deceased Current health or cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Alive/Deceased Current health or cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: # Alive\_\_\_\_\_\_\_\_ Current health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # Deceased\_\_\_\_\_\_\_\_\_\_\_ Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: # Alive\_\_\_\_\_\_\_\_ Current health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Deceased\_\_\_\_\_\_\_\_\_\_\_\_ Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD RELATIVE ILLNESSES:

Check all that apply

* Diabetes
* Cancer
* Kidney disease
* Tuberculosis
* Bleeding tendency
* Heart Disease
* Obesity
* High Blood Pressure
* Nerve disorder
* Allergies (seasonal/food)
* Alcoholism
* Mental Illness
* Aids/HIV
* Auto Immune
* ADD/ADHD
* Stroke
* Thyroid condition
* Asthma
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Medical History:

Health when you were a child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check illnesses or conditions that you have or have had in the past:

* Diabetes
* Cancer
* Kidney disease
* Tuberculosis
* Bleeding tendency
* Heart Disease
* Obesity
* High Blood Pressure
* Nerve disorder
* Allergies (seasonal/food)
* Alcoholism
* Mental Illness
* Aids/HIV
* Auto Immune
* ADD/ADHD
* Stroke
* Glaucoma
* Thyroid Condition
* Asthma
* Vein issues
* Jaundice
* STD
* Mumps
* Pneumonia
* Rheumatic fever
* Measles
* Chicken Pox
* Meningitis
* Mononucleosis
* High fevers
* Lots of antibiotic use
* Hepatitis
* Polio
* Gallbladder trouble
* Bladder infections
* Candidisis
* Kidney stones
* Parasites
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries and year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other serious injury, broken bones, or scars: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females:

Are you pregnant? Yes No Unsure How many months? \_\_\_\_

Are you trying to get pregnant? Y/N How many: Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions\_\_\_\_\_\_

Age: of first period \_\_\_\_\_\_\_ Menopause (if applicable) \_\_\_\_\_\_\_\_\_

History of abnormal pap smears? \_\_\_\_\_\_\_\_\_\_ Regular menstrual cycle? \_\_\_\_\_\_

Do you have any of the following menstrual symptoms?

* Pms
* Cramps
* Breast distention
* Bleeding between periods
* Very heavy flow
* Very light flow
* Blood clots
* Frequent UTIs
* Frequent yeast infections

Males:

* Frequent need to urinate (especially at night)
* Pain or swelling in testicles
* Erectile dysfunction
* Impotence

Have you sought medical help for any of the above? Y/N

General Medical for Males and Females:

Have you had any recent (past year) immunizations? If yes what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of: Last Physical \_\_\_\_\_\_\_\_ Cholesterol test\_\_\_\_\_\_\_\_\_ HIV test \_\_\_\_\_\_\_\_\_

Prostate test \_\_\_\_\_\_\_\_\_ Mammography \_\_\_\_\_\_\_\_\_\_\_

Blood tests (which kind) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale from 1 – 10 (1 being none and 10 being the most extreme you can imagine) What is your current level of stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep to you normally get? \_\_\_\_\_\_\_\_ Usual bedime? \_\_\_\_\_\_\_

Do you feel rested when you get up? Y/N How often do you wake up?\_\_\_\_\_\_\_\_

Do you exercise? Y/N If yes how many hours a week? \_\_\_\_\_\_\_\_\_

What do you do for exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a spiritual or religious practice? Y/N

Do you practice prayer or meditation? Y/N How many times a week? \_\_\_\_\_\_\_

Are you currently receiving care from: \_\_\_\_\_\_ Medical \_\_\_\_\_ Dentist

\_\_\_\_ Naturopath \_\_\_\_\_ Acupuncturist \_\_\_\_\_ Chiropractor

 \_\_\_\_\_\_Physical Therapist \_\_\_\_\_\_ Massage Therapist \_\_\_\_\_\_\_ Nutritionist

**Symptoms chart:**

**General symptoms:**

* Nervousness, irritability, anxiety
* Mental tension, Moodiness, depression,
* Melancholy
* Tired, weak, lack of energy
* Sleeplessness, sleep too much
* Frequent colds or other illness
* Headaches (whole head, back of head, forehead, temples, migraine)
* Don’t sweat enough/ Sweat too much/Night sweats
* Dizziness, fainting, seizures
* Loss or gain of weight

**Eye, Ear, Nose and throat:**

* Nearsightedness, farsightedness
* Blurred, failing vision, night blindness
* Dryness, burning, itching
* Eyes water excessively
* Sensitivity to light, floaters
* Bloodshot, puffy eyes
* Earaches
* Noises, ringing in ears
* Ear discharge, excessive wax
* Loss of hearing
* Difficulty breathing/Asthma
* Shortness of breath on exertion
* Spitting up mucus or blood
* Clear throat a lot
* Hay fever, sinusitis, runny nose
* Dry mouth, nose or lips
* Nosebleeds, bleeding gums
* Sore throats, tonsillitis
* Cold sores, herpes
* Loss of smell or taste
* Hoarseness

**Cardiovascular:**

* Irregular or fast heart beat
* Pacemaker
* Chest tightness
* Dizziness/weakness on standing
* Swollen feet, ankles or legs
* Cold hands or feet
* Hands or feet turn blue
* Leg pains when walking
* Varicose veins
* Tendency to anemia
* High blood pressure
* Low blood pressure
* Gastrointestinal:
* Loss of appetite
* Gagging, difficulty swallowing
* Nausea, vomiting
* Bad breath, taste in mouth
* Food cravings i.e. sweet, salty, other
* Heartburn, indigestion or distress
* Heaviness or fatigue after eating
* Gas, belching, bloating
* Stomach or abdomen tender or painful
* Symptoms relieved/worsened after eating
* Sensitivity/avoid certain foods
* Headache, dizziness, irritability if meals are skipped
* Diarrhea or loose stools
* Constipation
* Light colored or greasy stools
* Dark stools, blood in stools
* Undigested food in stools
* Feeling of incomplete evacuation
* Foul odor of stool or gas
* Hemorrhoids, anal fissure

**Urinary:**

* Difficulty urinating
* Urinate frequently at night
* Bed wetting
* Incomplete urination or dribbling
* Pain when urinating
* Bladder infections
* Kidney infections
* Kidney stones

**Skin and Hair:**

* Acne, pimples
* Skin rashes, hives
* Skin ulcers or sores
* Hair loss, thinning
* Bruise easily
* Moles, warts, skin tags
* Sunburn easily
* Cuts heal slowly, scar badly
* Dryness, roughness, scaling:
* Athlete’s Foot, toe fungus

**Nutritional Evaluation**:

Do you adhere to a particular food philosophy or have a special diet? Y/N

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do skip meals? Y/N Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any foods that you dislike/avoid or have sensitivities/allergies to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please put what you have eaten the last 24 hours:

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you drink a day/week?

Water\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use:

Tobacco: Y/N Amount per week?\_\_\_\_\_\_\_\_

Former smoker?\_\_\_\_\_\_ When quit?\_\_\_\_\_\_\_\_

Marijuana/Recreational drugs? Y/N Amount per week?\_\_\_\_\_\_\_\_\_

Please mark the areas of concern:

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