

## Confidential Intake Form

Date of Initial Visit \_\_\_\_\_

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

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact phone \_\_\_\_\_

Marital/Relationship status \_\_\_\_\_ Referred by \_\_\_\_\_

### Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

I agree to give at least 24hourse notice of cancellation of appointment.

Cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care.

I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice)

As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)

I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist/Practitioner signature: \_\_\_\_\_ Date \_\_\_\_\_

HIPAA regulations require all practitioners should have a signed release form from their client *before* taking any notes about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Practitioners should have this form signed before taking any notes. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. Failure to comply with these confidentiality regulations could result in penalties.

I, (name) \_\_\_\_\_

I give my permission, for Barbara Loomis to take notes about me, including health history/ medical and /or personal information

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Revised on 08/11/11

**Reason For Visit**

Primary reason for visit: \_\_\_\_\_

When did your first notice it? \_\_\_\_\_ What brought it on? \_\_\_\_\_

Describe any stressors occurring at the time \_\_\_\_\_

What activities provide relief? \_\_\_\_\_ what makes it worse? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_ interfere with work \_\_\_\_\_ sleep \_\_\_\_\_ recreation \_\_\_\_\_

Have you had massage/bodywork before? \_\_\_\_\_ What type? \_\_\_\_\_

**Medical History**

Are you currently under the care of another health care provider(s)? \_\_\_\_\_ Reason (s) \_\_\_\_\_

Name(s) of Practitioner \_\_\_\_\_ Address: \_\_\_\_\_

Phone \_\_\_\_\_ email \_\_\_\_\_

Current Medications and /orSupplements/Remedies: \_\_\_\_\_

Allergies: specify allergen and reaction: \_\_\_\_\_

Surgical History (year and type) and/or Recent Procedures: \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Accidents or Traumas \_\_\_\_\_

Falls/Injuries to Sacrum/head/tailbone (describe) \_\_\_\_\_

Other: \_\_\_\_\_

Please review and check the following:

Headaches Type:	Past	Present	Pins and Needles in arms, legs, Hands or feet	Past	Present
Asthma			Spinal Problems		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Loss of smell or Taste			Loss of Memory		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Muscular Tension: Location:		
Painful/Swollen Joints			Herniated/Bulging Discs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artificial/Missing limbs		

**Other (not mentioned above)**

Do you use Tobacco? \_\_\_\_\_ Quantity \_\_\_\_\_/ppd    Alcohol? \_\_\_\_\_ Quantity \_\_\_\_\_ ounces/ day  
 Marijuana? \_\_\_\_\_ Quantity \_\_\_\_\_ Other: \_\_\_\_\_ Have you been under treatment for substance use? \_\_\_\_\_

**Family History**

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			

Paternal  
Grandfather  
Other:

Digestion and Elimination

Typical Breakfast: \_\_\_\_\_  
Typical Lunch: \_\_\_\_\_  
Typical Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_ Water Intake(glasses/day) \_\_\_\_\_ Caffeine \_\_\_\_\_  
What is the worst item in your diet \_\_\_\_\_ What foods are your weakness \_\_\_\_\_  
Are you subject to binge eating? \_\_\_\_\_ What foods \_\_\_\_\_  
Do you experience bloating/gas/burps after eating? \_\_\_\_\_ What foods trigger this? \_\_\_\_\_  
How often are your bowel movements? \_\_\_\_\_ Do your stools: sink \_\_\_\_\_ float \_\_\_\_\_  
Constipation? \_\_\_\_\_ Blood in stool? \_\_\_\_\_ Mucus in stool? \_\_\_\_\_ Pain when stooling? \_\_\_\_\_  
Other concerns \_\_\_\_\_

EMOTIONAL & SPIRITUAL

What is your opinion of yourself? \_\_\_\_\_  
If possible, please describe the most negative emotion you experience \_\_\_\_\_  
When do you most often feel this emotion: \_\_\_\_\_ Where are you? \_\_\_\_\_  
Do you pray to or have a spiritual practice \_\_\_\_\_  
On a scale of 1 – 10 ( 1 being the lesser, 10 the greater) Please rate yourself:  
Worry \_\_\_\_\_ Hope \_\_\_\_\_ Resentment \_\_\_\_\_ Joy \_\_\_\_\_ Anger \_\_\_\_\_  
Fear \_\_\_\_\_ Grief \_\_\_\_\_ Other (describe briefly) \_\_\_\_\_  
What are hobbies/ activities that provide you with a sense of pleasure and accomplishment \_\_\_\_\_  
Describe your exercise routine (type, frequency) \_\_\_\_\_  
What changes would you like to achieve in 6 months \_\_\_\_\_ One Year \_\_\_\_\_

# MALE ~ REPRODUCTIVE HEALTH HISTORY

Check and Describe those symptoms as applicable

Headaches: Migraine \_\_\_\_\_ Tension \_\_\_\_\_ Cluster \_\_\_\_\_ Low back pain \_\_\_\_\_ Sore heels \_\_\_\_\_  
Varicose \_\_\_\_\_

Veins \_\_\_\_\_ Location \_\_\_\_\_ Numbness in  
legs/feet \_\_\_\_\_

Family History of Prostate Disease: \_\_\_\_\_ Type \_\_\_\_\_ Relationship \_\_\_\_\_

Family History of Cancer \_\_\_\_\_ Type \_\_\_\_\_ Relationship \_\_\_\_\_

History of sexually transmitted disease? \_\_\_\_\_ When \_\_\_\_\_ Type \_\_\_\_\_

Rate your interest in Sex:

High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_ None \_\_\_\_\_

Do you have or ever had difficulty experiencing orgasms \_\_\_\_\_ Have you experienced a history of:

rape \_\_\_\_\_ trauma \_\_\_\_\_ incest \_\_\_\_\_ If so, when \_\_\_\_\_ Did you undergo counseling for

this \_\_\_\_\_ What was this like for you?

Painful urination \_\_\_\_\_

Bladder/Kidney infections \_\_\_\_\_

Frequent Urination \_\_\_\_\_

Nocturnal Urination/ Frequency \_\_\_\_\_

Changes in urinary stream (describe flow, stream, strength of stream) \_\_\_\_\_

When did you first notice these symptoms \_\_\_\_\_

Are they getting better or worse \_\_\_\_\_ Describe \_\_\_\_\_

**Erectile Function** (describe as indicated)

Difficulty obtaining an erection \_\_\_\_\_ Difficulty maintaining an erection \_\_\_\_\_ Painful ejaculation \_\_\_\_\_

Is there a history of back injury/trauma? \_\_\_\_\_

Describe: \_\_\_\_\_

When did you first notice these symptoms \_\_\_\_\_

Are they getting better or

Worse? \_\_\_\_\_ Describe \_\_\_\_\_

Current Medications or Supplements: \_\_\_\_\_

Results of PSA (prostate specific antigen) Test if known \_\_\_\_\_ Date done: \_\_\_\_\_

Results of Sperm count (if applicable and known) \_\_\_\_\_ Date  
done: \_\_\_\_\_

Additional Comments:

\_\_\_\_\_

## Business Policy

Barbara Loomis, LMT  
503-341-0663

**Appointments:** An appointment is a time set-aside for you and it is a time, which is carefully planned within the context of the week's schedule. My time is very important to me, as I am sure yours is to you. Missed appointments or short notice cancellations are times I could have scheduled someone else, therefore without advanced notice it becomes an income loss for me. Please notify me at least 24 hours in advance to avoid being charged if you have to cancel your appointment. This courtesy enables me to re-arrange my time.

When you make an appointment, I schedule that block of time for your session. In order for me to stay on schedule out of a courtesy for others and yourself I need to stay within that block of time. If you are late for the appointment, I will use the remaining time in the most productive way, and the total fee for the session will be charged to you. My main priority is to help you in the best way that I can, so it is to the benefit of both of us if you can arrive on time. I know sometimes things happen that are out of our control and if I happen to have extra time I am always happy to spend it with you at no additional charge.

Fees: 90 minutes=\$108.15 60 minute sessions= \$77.25

With cash discount total is- 90 minutes=\$105 60 minutes=\$75

The above fees are for payments received on the *same* day of service and without the cash discount. I offer a **3% discount for cash payments on services**. Payments are due on the date of service in the form of cash, check or credit card. Payments made after date of service will be billed at \$28 per 15-minute increment. There is a \$25 check return fee.

Type or Print Name: \_\_\_\_\_

Signature \_\_\_\_\_

Email Address \_\_\_\_\_

I will never share your information with anyone.

**“Like” Nurturance on Facebook to receive updates, tips and announcements of sales.**

Date \_\_\_\_\_