Intake Form

Please complete this form with as much detail as you can. Your information is important to me and will be held in the utmost confidence.

Name and Date

____

Date of Birth ___/___/___

Age _______

Complete Address (street, city, state, zip)

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Phone number_______________________**Email**_______________________________________

Emergency Contact Name and Phone Number

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How did you hear about me?

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What is your main concern and what do you wish to achieve from these sessions?

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Briefly tell me about your medical history (injuries, accidents, surgeries, etc.)

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What is your body telling you right now? What symptoms are you experiencing?

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Please mark any concerns you have regarding the following areas:

__ ***Low energy***
__ ***Spaciness, dizziness***
__ ***Memory issues, brain fog***
__ Headaches, migraines
__ Colds, flu
__ earaches, tinnitus
__ TMJ
__ sinus problems
__ Sleep disorders, snoring
__ Learning disorders
__ ***Neck, shoulder or arm pain***
__ ***Swollen glands***
__ ***Food sensitivities***
__ ***Tiredness after eating***

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__ ***Breathing issues, asthma***
__ ***Chest pain, heartburn***
__ ***High or low blood pressure***
__ ***Gas, burping***
__ ***Trouble with fatty foods, indigestion***
__ ***Kidney & bladder problems***
__ Lower back pain *
__ Disc problems
__ Digestive & reproductive complaints
__ ***Sciatica**** *
__ ***Hip issues, groin problems***
__ Anxiety
__ Depression
__ Nervous system issues
__ Neurological

Please add any details to the above areas or ANYTHING else you feel I should be aware of.

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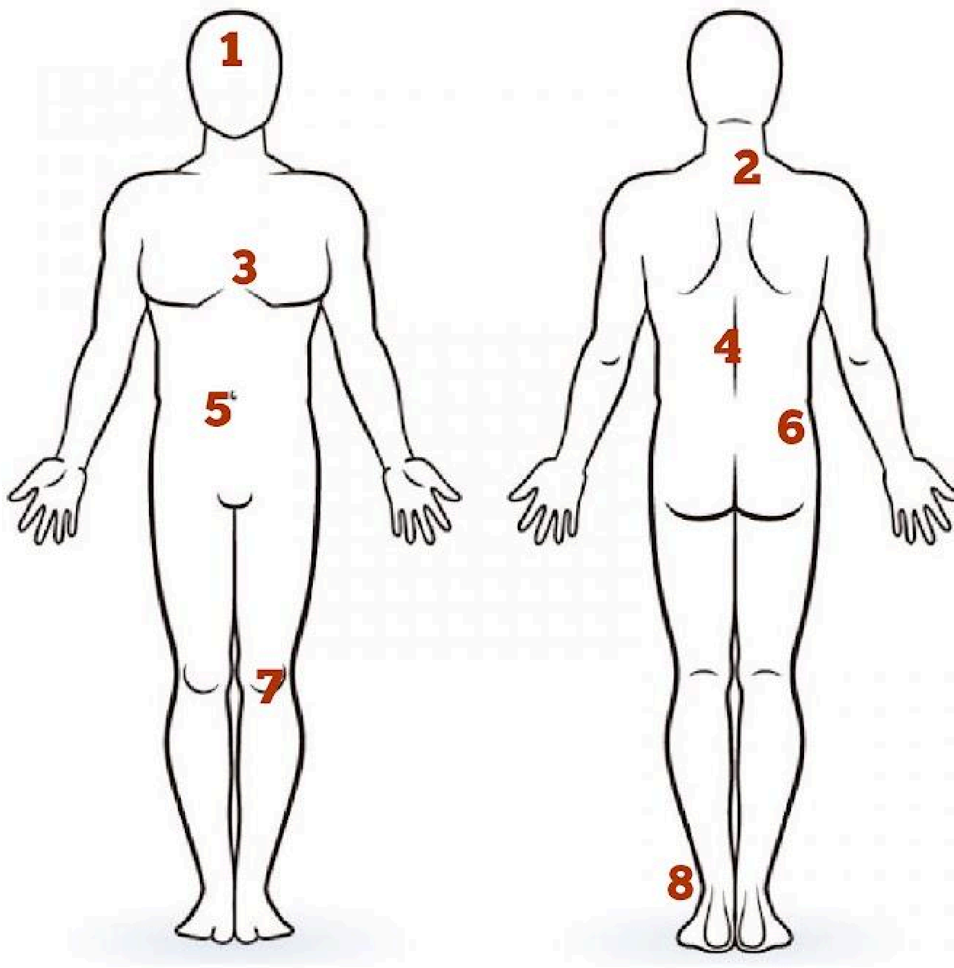
On the diagram below, mark all areas that are painful, stiff, sore or are areas of concern. Use the numbered list below the diagram for reference, if needed.



1. Head/Headaches
2. Neck/Shoulders
3. Chest
4. Back
5. Stomach
6. Hips
7. Knees/legs
8. 8 Feet/ankles

What are your current main health concerns in your PHYSICAL HEALTH, and what changes would you like to see?

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What are your current main health concerns in your EMOTIONAL HEALTH, and what changes would you like to see?

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What are your current main health concerns in your SPIRITUAL HEALTH, and what changes would you like to see?

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Are you living the life you would like to be? Please choose one.

__ YES

__ NO

How would your life be different if the above changes were made?

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I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals.

I understand that the therapist is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailment that might concern me.

I understand this care is designed to assist the body with healing by helping to remove traumas from the body. I understand that healing takes time and health is a process.

I understand that with any healing process and work on my body, my symptoms may worsen before they get better.

I understand that information exchanged during sessions is educational in nature and is intended for me to become more familiar and conscious of my own health status and is to be used at my own discretion.

I have stated all of my known health conditions and take it upon myself to keep the therapist updated on my health. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

I agree and give consent to the healing work. Please choose one.

__ Agree

__ Disagree

Signature ____**Date**_____________________

If you have any questions please reach out to
Joyce at (541) 517-2514

Spinal Flow Technique can help the body move from a state of stress to a state of ease where healing can happen.