**CheneyHolistic**

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## General Intake Form

A complete intake form helps to ensure that you are provided with a safe and effective treatment. Please advise if your status changes this way your form can be updated. All information you provide is strictly confidential.

Name ____________________________________ Email _________________________________

Home Phone ___________________ Cell Phone __________________ Work Phone _____________

Street Address _________________________________________________________________________

City __________________ Province ________________ Postal Code _________________________

Date of Birth ______________________________ Occupation _______________________________

Doctor's Name ______________________________ Phone Number ___________________________

Last Check Up _______________________________

Do you see other practitioners (please circle)?

Chiropractor Physio Naturopath Osteopath RMT Other

Current Medications

_____________________________________________________________________________________

_____________________________________________________________________________________

Previous Major Illnesses / Operations (include dates) _________________________________________

Allergies / Hypersensitivities______________________________________________________________

Major Accidents (include dates) ____________________________________________________________

Other Serious Medical Conditions ___________________________________________________________

Any further information you wish to provide?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**What you might experience during or after the treatment:**

- Deep relaxation
- Falling asleep
- Release from stress
- Pain from reflex points
- Temporary worsening of presenting and/or the underlying condition
- A feeling of being generally unwell
- Headaches
- Feeling tired, listless, emotionally upset, irritable, restless, depressed, hot or cold

OVER, PLEASE

CheneyHolistic

## Health History Form (please circle all that apply)

**General Symptoms**
Difficulty Sleeping / Fatigue
Fainting / Dizziness
Headaches / Migraines
Nervousness
Numbness / Tingling ______
Paralysis
Stress

**Skin**
Acne
Bruise Easily
Eczema
Excessive Dryness
Psoriasis
Rashes
Skin Cancer

**Infections**
Athlete's Foot
Hepatitis
Herpes
HIV / Aids
Tuberculosis
Warts

**Respiratory**
Asthma
Bronchitis
Chronic Cough
Emphysema
Family History of ______
Shortness of Breath

**Lifestyle**
Regular Exercise Yes No Mostly
Drink lots of Water Yes No Mostly
8 Hrs Sleep Nightly Yes No Mostly
Good Eating Habits Yes No Mostly

What is your general healthy overall? ______________________

**Joint / Muscle Discomfort**
Arms
Arthritis
Bursitis
Feet
Hands
Hips
Jaw
Knees
Legs
Lower Back
Mid Back
New
Shoulders
Upper Back
Family History of Arthritis

**Do You Have / Had?**
Aneurysm / Stroke
Artificial Implants / Pins / Plates
Cancer; Type _______
Depression
Diabetes Onset ______
Epilepsy
Fibromyalgia
Hypo / Hyper Glycemic
Mental Illness
Multiple Sclerosis
Neuromuscular Conditions
Osteoporosis
Thyroid Problems

**Female / Male**
Birth Control
Breast Pain / Lumps
Endometriosis
Menopausal
Menstrual Cramping
Menstrual Irregularity
Pregnant; Trimester ______
Prostate
Vagina Pain / Infections

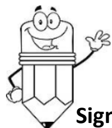
**Cardiovascular**
Cold Hands / Feet
Congestive Heart Failure
Family History of _____
Feet
Heart Attack / Disease
Heart Murmur
High Blood Pressure
High Cholesterol
Low Blood Pressure
Pacemaker
Poor Circulation
Stroke / Aneurysm
Swelling of Ankles
Varicose Veins / Phlebitis

**Gastrointestinal**
Abdominal Cramps
Colitis
Constipation
Crohn's
Diarrhea
Excessive Thirst
Gall Bladder Problems
Gas / Bloating
IBS
Kidney / Bladder Issues
Liver Problems
Nausea / Vomiting
Poor / Excessive Appetite
Ulcer

**Eye / Ear / Nose / Throat**
Allergies
Dental Problems
Ear Aches
Hearing Aids
Hearing Difficulty
Sore Throat
Stuffed Nose / Sinus
Swollen Glands
Vision Problems

**Please read and sign:**

- I could, if the need arises, withdraw my consent and stop the treatment t any time throughout the procedure.
- I understand that the Practitioner does not diagnose, prescribe or treat for specific conditions and that the sessions I receive is not a substitute for a medical treatment, but a complimentary modality.
- The procedure, its risks and benefits have been explained to me, and I understand the explanation given.
- I agree that the above information is true.
- I hereby agree for the treatment to be carried out on me.
- I understand that the record of the treatment given shall be kept. This record is confidential and will not be disclosed to an outside party, unless authorized by me, my representative, or as ordered by the court of law to do so.



**Signature** ___________________________________________ **Date** _________________________