Confidential Intake Form Instructions:

Please fill out only the sections you are comfortable with. Print the form and bring it with you. If you need to come early to complete the form, please let us know so we can make arrangements.

Personal Information

Name: _____
Date: _____

Date of Birth: _____
Home Number: _____
Cell Number: _____

Emergency Contact: _____
(Name) (Relationship) (Number)

Medical Information

Are you presently taking any medication?
___ Yes ___ No
Please Explain: _____

Have you had a recent major surgical procedure or injury?
___ Yes ___ No
Please Explain: _____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?
___ Yes ___ No
Please Explain: _____

Surgical History

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

Hospitalizations:

Accidents or Traumas:

Falls/Injuries to Sacrum/head/tailbone (describe):

Conditions

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/Fractured bones
- Strains/Sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Other: _____

Comments:

Digestive

- Indigestion
- Constipation
- Intestinal gas/bloating

- Diarrhea
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Loss of Appetite
- Ulcers
- Other: _____

Comments:

Skin

- Rashes
- Allergies
- Athlete's foot
- Acne
- Impetigo
- Hemophilia
- Other: _____

Comments:

Nervous System

- Depression
- Difficulty concentrating
- Numbness/tingling
- Hearing Impaired
- Fatigue
- Visually Impaired
- Sleep disorders
- Diabetes
- Fibromyalgia
- Paralysis
- Post-Polio Syndrome
- Herpes/shingles
- Cancer
- Cerebral Palsy
- Tuberculosis
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis

- Muscular Dystrophy
- Parkinson's Disease
- Other: _____

Comments:

Circulatory/Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Stroke
- Heart condition
- Allergies
- Asthma
- High blood pressure
- Low blood pressure
- Other: _____

Comments:

Reproductive System

- Pregnancy
- Other: _____

Comments:

Female Reproductive Health History

When did you begin your menses? _____
What was this like for you? _____

How many pregnancies have you had? _____
Number of deliveries: _____ Dates:
_____

Terminations: _____ When?
_____

Miscarriages: _____ When?
_____

Complications:
_____

What was your experience of:

- **Pregnancy**:
  _____
- **Labor**:
  _____
- **Delivery**:
  _____
- **Post Partum**:
  _____

Medications your mother took when she was pregnant with you (if any):

Birth Trauma (if known):
_____

Maternal Family History of (please circle):

- Infertility
- Fibroids
- Endometriosis
- PMS
- Menopause
- Cancer (type): _____
- Menstrual Problems
- Other: _____

Method of Contraception (circle):

- Pills
- Patch
- Diaphragm
- Injection
- Condoms
- IUD
- Abstinence
- Rhythm method
- Fertility Awareness

- Other: _____
  Length of time using method: _____

Last Pap smear: _____ Results (if known):
_____
Date of Last Menstrual period: _____ Length of Menses: _____
Are you Pregnant/Trying to Conceive? _____
Episodes of Amenorrhea: _____ When? _____ For how long?
_____

Symptoms (Please check if applicable):

- Painful Periods
- Irregular Cycles (early or late)
- Dark, thick blood at beginning of cycle
- Dark, thick blood at end of cycle
- Headache or Migraine with period
- Dizziness with period
- Bloating/Water Retention with period
- Heaviness in pelvis with period
- PMS/Depression with or before period
- Excessive Bleeding (> one pad/hour)
- Failure to Ovulate
- Painful Ovulation
- Varicose Veins
- Tired weak legs
- Numb legs and feet when standing
- Sore heels when walking
- Low back ache
- Painful intercourse
- Constipation
- Endometriosis
- Endometritis/Uterine Infections
- Uterine Polyps
- Fibroids
- Vaginal Discharge/Vaginitis
- Bladder Infections/Incontinence
- Chronic Miscarriage
- Weak newborn infants
- Premature deliveries
- Incompetent cervix
- Spotting with pregnancy
- Pelvic Inflammation

- Sexually Transmitted disease
- Dry Vagina
- Difficult menopause
- Cancer esp. of reproductive area
- Cysts esp. breast/ovarian
- Other: _____

Are you under treatment for Infertility? ___ Yes ___ No
Describe current treatment to date (IUI, IVF, etc.):

Gynecological Provider: _____
Have you experienced a history of rape, trauma, or incest? ___ Yes ___ No
If so, when? _____
Did you undergo counseling for this? ___ Yes ___ No

Agreement

I understand that Suzi Wilkoffr does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times. If I become uncomfortable for any reason, I may ask the therapist to end the session, and they will do so. I understand that the practitioner may end the session due to any inappropriate behavior. I have disclosed all conditions I am aware of, and this information is true and accurate. I will inform the healthcare provider of any changes in my status.

Cancellation Policy

A 48-hour notice is required for changes or cancellations. The full session fee will be charged for cancellations with less than 48 hours' notice. Please inform the practitioner if you have an emergency.

Client's Signature: _____ Date: _____