# Health Intake Form

Name: _____Birth Date: _____

Address: _____Postal Code: _____

Telephone: (Home)_____(Bus.)_____(Cell)_____

E-mail: _____Doctor's Name: _____Tel._____

What is your occupation? _____ How long? _____

Are you in good health? _____

What are you doing for your health? _____

Diet? _____

Exercise? _____

Do you sleep well? _____Explain: _____

Describe your energy level. _____

Do you tend to feel hot or cold? (sweat?) _____

In what circumstances? _____

Emotional state: _____

Do you suffer from anxiety or worry? Yes □ No □ Sometimes □

Are you pregnant? _____ If yes, which trimester? _____

Do you have allergies/sinus conditions? _____

Do you have varicose veins? Yes □ No □ Location: _____

Please indicate your consumption level of the following:

| | NONE | LIGHT | MODERATE | HIGH |
|---|---|---|---|---|
| Salt | □ | □ | □ | □ |
| Sugar | □ | □ | □ | □ |
| Caffeine | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Alcohol | □ | □ | □ | □ |
| Exercise | □ | □ | □ | □ |
| Water | □ | □ | □ | □ |

Are you experiencing any of the following?

Inflammation □ Headache □ Skin rash □ Cold/flu □ Cuts, bruise, burn □ Decreased range of motion □

When did you last visit your doctor? _____ Reason: _____

List past injuries and time of it. _____

List past surgeries and time of it. _____

Are you taking any medications? (Please include vitamins or supplements.)

_____

Are you undergoing other therapies? Yes_____ No_____ List: _____

Do you have pain in a particular area? _____

What is it you have come to see me about? _____

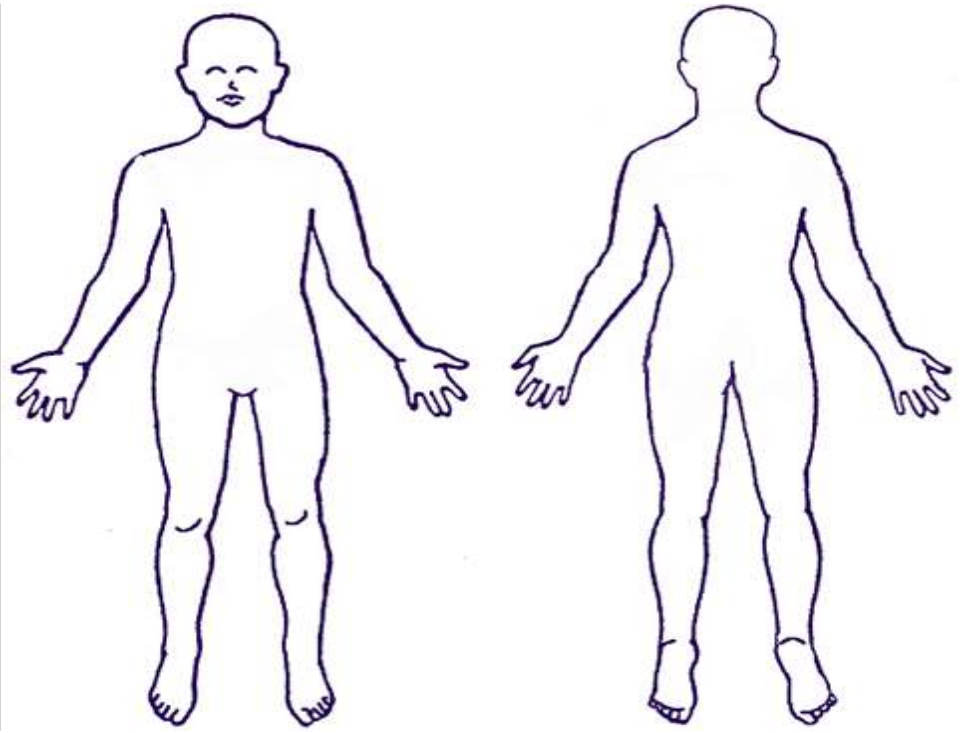
What have you tried for it? _____

Do you have any intentions for your session? _____

What do you wish to receive from your session? _____

Do you have any questions? _____

Please circle areas of discomfort or concern.



Front Back

**Do you have problems with any of the following systems?**

Endocrine System: **(Ex. diabetes, hypoglycemia, menopausal symptoms, hypothyroidism, hyperthyroidism)** **Y N**
**Specify:** _____

Urinary System: **(Ex. kidney disease, urinary problems)** **Y N**
**Specify:** _____

Cardiovascular: **(Ex. high/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia)**
**Specify:** _____ **Y N**

Immune & Lymphatic: **(Ex. arthritis, chronic fatigue, environmental illness, allergies etc.)** **Y N**
**Specify:** _____

Musculoskeletal: **(Ex. osteoporosis, fibromyalgia, bursitis, gout, back pain, scoliosis, arms, hands, wrists, legs, knees, ankles, foot etc.)** **Y N**
**Specify:** _____

Respiratory: **(Ex. breathing, coughing, asthma, emphysema, allergies, sinus problems etc.)** **Y N**
**Specify:** _____

Nervous: **(Ex. vision, hearing loss/problems, loss of sensation, numbness, tingling, nerve pain/damage, mental or emotional problems, MS etc.)** **Y N**
**Specify:** _____

Reproductive: **(Ex. PMS, irregularity, menopause, pregnant, dysmennorrhoea, endometriosis, prostate problems etc.)** **Y N**
**Specify:** _____

Digestive: **(Ex. constipation, diarrhea, Chrohn's Disease, colitis, ulcer, heart burn, indigestion etc.)** **Y N**
**Specify:** _____

Integumentary (Skin)**: (Ex. psoriasis, eczema warts etc.)** **Y N**
**Specify:** _____

Other: **(Tuberculosis, cancer, hepatitis, herpes, HIV/Aids etc.)** **Y N**
**Specify:** _____

## CONSENT TO RECEIVE TREATMENT

**I the undersigned consent to in clinic and virtual or online services received from Full Circle Bodyworks Inc., including but not limited to Reiki, Intuitive Healing, Cellular Regeneration, Access Bars, Chakra Balancing, Shiatsu, Relaxation Massage, Reflexology and Strength Training. I understand that these sessions are for stress reduction and relaxation; I may stop the session at any time. I understand the benefits and risks of these services and acknowledge these therapies are not a substitute for medical diagnosis or psychological conditions and treatment. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I agree to provide 24-hour notice for appointment changes and cancellations or will pay for my appointment in full.**

**Signature: _____Date: _____**