**Logo, company name

Description automatically generated**

**New Patient Intake Form**

**Personal Information**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Sex: □ Male □ Female

Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Province \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

Personal email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Common-Law

Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main health concerns that you would like addressed?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are female, are you currently pregnant? □ Yes □ No

**Medical history**

How would you describe your general state of health?

□ Excellent □ Good □ Fair □ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications, including dosages, duration of use and why you are taking them:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Duration** | **Condition Treating** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list all natural health products you are taking:

|  |  |  |  |
| --- | --- | --- | --- |
| **Natural Health Product** | **Dose** | **Duration** | **Condition Treating** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list **past** prescription medications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How frequently are you treated with antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly use any of the following?

□ Aspirin □ Laxatives □ Antacids □ Diet pills

□ Birth control pills □ Implants □ Injections

Please list any surgeries, dates of surgery and any complications (please include all cosmetic and elective surgeries as well as dental surgery)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies (medicines, environmental, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Average daily water consumption \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_

Sleep posture: side \_\_\_\_\_\_ back \_\_\_\_\_\_\_\_\_ stomach \_\_\_\_\_\_\_

Number of hours sleep per night \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of sleep (Refreshing, unbroken) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep environment (Quiet, peaceful, 100% darkness): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did/do you wear braces on your teeth? No \_\_\_\_\_ Yes \_\_\_\_\_ # months/years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did/do you wear a dental appliance? No \_\_\_\_\_ Yes \_\_\_\_\_\_

Did/do you have mercury dental amalgam? No \_\_\_\_\_\_ Yes \_\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? (Daily average) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? (Daily average) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weekly consumption of beverages? Coffee \_\_\_\_\_\_ Tea \_\_\_\_ Soft Drinks \_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

Do you use recreational drugs? (What and how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate which immunizations you have had:

□ DPT (diphtheria, pertussis, tetanus) □ Haemophilus influenza B □ Hepatitis A

□ Tetanus booster; when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ “Flu” □ Hepatitis B

□ MMR (measles, mumps, rubella) □ Polio □ Smallpox

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if any caused adverse reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? □ Yes □ No

When were your most recent tests performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **MUSCLES/JOINTS/NERVES**  C P  **Head and Neck**  \_\_ \_\_ headaches/migraines  \_\_ \_\_ neck pain/whiplash  \_\_ \_\_ tingling/numbness  \_\_ \_\_ tooth/jaw/ear pain/TMJ  \_\_ \_\_ vision condition (s)  \_\_ \_\_ hearing condition/dizziness  \_\_ \_\_ head trauma/concussion  \_\_ \_\_ loss of coordination  **Trunk**  \_\_ \_\_ back pain/injury/scoliosis  \_\_ \_\_ degenerative/herniated disc  \_\_ \_\_ hip pain/sciatica  **Arms / Hands / Legs / Feet**  \_\_ \_\_ pain/tingling  \_\_ \_\_ weakness/numbness  \_\_ \_\_ fractures/strains/sprains  \_\_ \_\_ tendonitis/fibrositis/bursitis  \_\_ \_\_ osteo/rheumatoid arthritis  \_\_ \_\_ muscle/nerve disease  **Skin**  \_\_ \_\_ lack of sensation/numbness  \_\_ \_\_ irriated condition/frostbite  \_\_ \_\_eczema/psoriasis/skin infection | **HEART/CIRCULATION**  C P  \_\_ \_\_ high/low blood pressure  \_\_ \_\_ chest pain/angina  \_\_ \_\_ heart attack/stroke  \_\_ \_\_ heart disease  \_\_ \_\_ pacemaker  \_\_ \_\_ bruise easy  \_\_ \_\_ arrhythmia  \_\_ \_\_ phlebitis/thrombosis  **LUNGS RESPIRATION**  \_\_ \_\_ shortness of breath  \_\_ \_\_ chronic cough  \_\_ \_\_ asthma bronchitis  \_\_ \_\_ emphysema  **DIGESTION**  \_\_ \_\_ IBS/Crohn’s/colitis  \_\_ \_\_ Celiac disease  \_\_ \_\_ constipation/diarrhea (chronic)  \_\_ \_\_ nausea/bloating/gas (chronic)  \_\_ \_\_ ulcer/hernia  **UROGENITAL**  \_\_ \_\_ liver/gall bladder  \_\_ \_\_ urinary infection/disease  \_\_ \_\_ kidney infection/disease | **GENERAL/SYSTEMIC**  C P  \_\_ \_\_ anxiety/stress  \_\_ \_\_fatigue/insomnia  \_\_ \_\_eating disorder  \_\_ \_\_drug/alcohol issues  \_\_ \_\_ fibromyalgia/chronic fatigue  \_\_ \_\_ osteoarthritis/osteoporosis  \_\_ \_\_inflammatory arthritis  \_\_ \_\_diabetes  \_\_ \_\_ undiagnosed lump  \_\_ \_\_cancer  \_\_ \_\_epilepsy  \_\_ \_\_TB/hepatitis/HIV  \_\_ \_\_internal pins/plates/wires  \_\_ \_\_artificial joints  **WOMEN**  \_\_ \_\_ menstrual changes/problems  \_\_ \_\_endometriosis  \_\_ \_\_PMS/menopausal complications  \_\_ \_\_other gynecological conditions  \_\_ \_\_pregnant –due date? \_\_\_\_\_\_\_\_\_\_  \_\_ \_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MEN**  \_\_ \_\_ prostrate problem  \_\_ \_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**All Current (C) and Past Conditions (P). Check box if applicable; Circle specific conditions.**

**Pregnancy and Gynecology – Women only**

Age at first menses \_\_\_\_\_\_\_Length of cycle \_\_\_\_\_\_\_\_ Duration of menses \_\_\_\_\_\_\_\_\_\_

□ Unusual menses □ Painful periods □ Clots □ Heavy ٱ Light

□ Irregular periods □ Last PAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Vaginal discharge

□ Vaginal sores □ Breast lumps

□ Changes in body / psyche prior to menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you practice birth control? Y /N

What type and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could you be pregnant now? Y/N (circle Yes if it is possible)

1st day of last menses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_

These pregnancies resulted in:

Premature births: \_\_\_\_\_\_ Abortion: \_\_\_\_\_\_\_ Miscarriage: \_\_\_\_\_\_\_

Full term birth: \_\_\_\_\_\_ Postdate birth: \_\_\_\_\_\_\_

Any other obstetrical or gynecological issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet**

Do you have any food allergies or intolerances? Please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History (**□ I don’t know my family medical history)

Indicate if a close relative (parent, child, sibling) has had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Who? |  | Who? |
| Allergies |  | Depression |  |
| Asthma |  | Other mental illness |  |
| Heart disease |  | Drug abuse/alcoholism |  |
| High blood pressure |  | Kidney disease |  |
| Cancer |  | Other |  |
| Diabetes |  |  |  |

**Environment**

Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? □ Yes □ No

What do you do for exercise, for what duration and how often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to significant tobacco smoke (at work, home, etc.)? □ Yes □ No

Are you frequently exposed to animals (work, pets, etc.)? □ Yes □ No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe the emotional climate of your home?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your stress levels?

□ Overwhelming □ High □ Moderate □ Low □ Minimal

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Statement of Acknowledgement**

Each patient seeking care from Soul Remedy Holistic Clinic should understand that the Bowen Practitioner is certified and specialized in Bowen Therapy and specialized in Heilkunst Treatment and is not a Medical Doctor. If standard medical diagnosis or treatment is required, it must be obtained from a licensed Medical Doctor.

**Patient Consent Form**

Privacy of your personal information is an important part of providing you with quality care. This document is confidential information and will not be released to any persons without your consent.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_