Carrie Jones, N.D.

By acting on your health now – the future will change accordingly™

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____Date of Initial Visit: _____

Address:_____State: _____ Zip: _____

Preferred Phone: _____Second phone: _____Email: _____

Date of Birth: _____ Age: _____ Occupation: _____

Marital Status: _____ Referred By: _____

Have you had massage/bodywork before? _____ What type? _____

REASON FOR VISIT

What is your primary concern? _____

What are other areas of concern? _____

When did you first notice it? _____What brought it on? _____

Describe any stressors occurring at the time: _____

What activities provide relief? _____ What makes it worse? _____

Is this condition getting worse?_____Interfere with work _____ Sleep _____ recreation _____

Describe your exercise routine (type, frequency) _____

FAMILY HISTORY

	Alive?	Age/Cause of Death	Major Health Issues
Mother:			
Father:			
Siblings:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			

Family History of Abuse: _____ Circle if Applicable: physical emotional sexual spiritual

Family History of Substance Abuse: _____ Suicide: _____ Other Trauma: _____

Have you experienced a history of: Rape _____ Trauma _____ Incest _____ If so, when: _____

Did you undergo counseling for this? _____

What was this like for you? _____

DIGESTION & ELIMINATION

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____

Water intake (glasses/day) _____ Caffeine: _____

What is the worst thing on your diet? _____ What foods are your weakness? _____

Are you subject to binge eating? _____ What foods? _____

Do you experience bloating/gas/burps after eating? _____ What foods trigger this? _____

How often are our bowel movements? _____ Do your stools: Sink _____ Float _____

Constipation? _____ Blood in stool? _____ Mucus in stool? _____ Pain when stooling? _____

Other concerns? _____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself? _____

If possible, please describe the most negative emotion you experience _____

When do you most often feel this emotion? _____ Where are you? _____

Do you pray or have a spiritual practice? _____

On a scale of 1-10 (1 being lesser, 10 the greater) Please rate yourself:

Faith _____ Hope _____ Charity _____ Generosity _____ Sense of Humor _____

Sense of Fun _____ Fear _____ Grief _____ Other (briefly describe) _____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment? _____

What changes would you like to achieve in 6 months? _____ One year? _____

MEDICAL HISTORY

Are you currently under the care of another health care provider(s)? _____ Reason(s) _____

_____

Name(s) of practitioner _____ Phone (if known) _____

Address _____

Current Medications: _____

_____

Supplements/Remedies: _____

Allergies: specify allergen and reaction: _____

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Do you use Tobacco? _____ Have you ever? _____ Quantity_____/ppd

Alcohol use? _____ Quantity _____ drinks/week Marijuana? _____ Quantity? _____/week

Other: _____ Have you been under treatment for substance abuse? _____

If so, describe: _____

Surgical history (year and type): _____

_____

Recent Procedures: _____

Hospitalizations: _____

Accidents or Traumas: _____

Falls/injuries to sacrum/head/tailbone (describe) _____

Birth trauma if known: _____

Recent bloodwork? _____

Circle any of the following you are currently experiencing

Underline any of the following you have experienced in the past

Headaches (migraine, tension, cluster) Ringing in Ears Pins and needles in arms, legs, hands or feet

Asthma Cold Hands and Feet Swollen Ankles Sinus Conditions Seizures

Loss of Smell or Taste Skin Disorders: Acne, Fungus, Psoriasis, other: _____

Sciatica Painful Joints Swollen Joints Spinal Problems Anxiety Fatigue

Trouble Sleeping Fainting Spells Loss of Memory Depression

Muscular Tightness (location): _____ Varicose Veins (location): _____

Herniated or Bulging disc (location): _____ High Blood Pressure Low Blood Pressure

Contact Lenses Dentures Artificial/Missing Limb Frequent colds/Upper Respiratory condition

Mark any areas of persistent pain or tension on the figure below:

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FEMALE ~ REPRODUCTIVE HEALTH HISTORY

Age of first period? _____ What was this like for you? _____

How many pregnancie(s) have you had? _____ Number of Deliverie(s) _____ Date(s): _____

Termination(s): _____ When? _____

Miscarrige(s): _____ When? _____

Complications? _____

What was your experience of:

Pregnancy? _____

Labor? _____

Delivery? _____

Post Partum? _____

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

Maternal family history of (please circle): Infertility Fibroids Endometriosis PMS

Cancer (who & type) _____ Menstrual Problems Menopausal Difficulty

Method of Contraception (circle) Pills Patch Diaphragm Injection Condoms IUD Abstinence Ring Rhythm Method Other: _____

Length of time on synthetic contraception (pill,patich,ring,injection): _____

Last Pap Smear: _____ Results (if known): _____ Last Mammogram: _____ Results: _____

Last DEXA bone scan: _____ Results: _____ Last Colonoscopy: _____ Results:_____

Date of Last Menstrual Period: _____ Length of cycle: _____/days

Length of days bleeding: _____/days Number of pads/tampons used on heaviest day: _____

Months when you did not bleed? _____ When: _____ For how long? _____

Please circle as appropriate:

Painful Periods Irregular (late or early) Dark thick blood at the beginning or end of cycle

Dizziness with period Headache or migraine with periods PMS Depression with or before period

Failure to ovulate Painful ovulation Heaviness or pressure in lower pelvis with period

Bloating/water retention with period

Other Symptoms (Circle and Describe as indicated)

Varicose veins of legs Tired weak legs Numb legs and feet when standing still Spotting

Sore heels when walking Low back ache Painful intercourse Constipation Endometriosis

Endometritis (inflammation) Uterine polyps Fibroids (size and location) _____

Bladder infections Vaginal discharge (describe) _____ Vaginitis PCOS

Vaginal yeast infections Chronic miscarriages Premature deliveries Weak newborn infants

Difficult pregnancy Incompetent cervix Spotting with pregnancy Pelvic Infections

Dry vagina(without menopause) Sexually transmitted Disease (date and type) _____

Difficult menopause Cancer(cervix, bladder, uterus, ovarian, bowel) Cysts (ovarian or breast)

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Are you under the treatment for infertility? _____ Describe current treatment to date: _____

_____

Gynecological provider: _____ Address/Phone: _____

Rate your interest in sex: High_____ Moderate _____ Low _____ None _____

Do you have or ever have difficulty experiencing orgasm? _____

How would you describe your relationships? _____

MENOPAUSE (Circle the symptoms that apply to you)

Hot flashes Insomnia Fatigue Memory Loss Mood Swings Irritability

Vaginal Discharge (describe): _____

Dry vagina Depression Spotting (menses) Clotting Irregular menses

Increased/decreased Libido

Other symptoms not listed above: _____

_____

When did these symptoms again: _____

Are they getting: worse _____ Better _____ Same _____ Last menstrual period: _____

Are you on/or have ever been on hormone replacement therapy? _____ If so, how long? _____

Name and dose: _____

Reason for stopping: _____

Other medications/herbal remedies: _____

Age of Mother at menopause: _____ Concerns/Experience: _____

Additional Comments:

MALE ~ REPRODUCTIVE HEALTH HISTORY

Headaches: Migraines _____ Tension _____ Cluster _____ Low back pain _____

Sore heels _____ Varicose veins(location) _____ Numbness in legs/feet _____

Family history of prostate disease: _____ Type _____ Relationship _____

Family history of cancer: _____ Type _____ Relationship _____

History of sexually transmitted disease _____ When _____ Type _____

Rate of your interest in sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasm _____

Have you experienced a history of: rape _____ Trauma _____ Incest _____ if so, when _____

Did you undergo counseling for this? _____

What was this like for you? _____

URINARY SYMPTOMS (Circle those applicable)

Painful urination Bladder/Kidney infections Frequent urination Nocturnal Urination/Frequency

Changes in urinary stream (describe flow, stream, strength of stream) _____

Are they getting: Worse _____ Better _____ Same _____ When did they start? _____

ERECTILE FUNCTION (Describe as indicated)

Difficulty obtaining an erection Difficulty maintaining erection Painful ejaculation

Is there a history of back injury/trauma? _____ Describe _____

When did you first notice these symptoms? _____

Are they getting: Better _____ Worse _____ Same _____

Current medications or supplements: _____

_____

Results of PSA test: _____Date done: _____Digital Rectal exam results: _____Date done: _____

Result of Sperm count (number, mobility, morphology) _____

_____

PLEASE READ AND SIGN

Client Confidentiality Release Form

I, (name) _____ Address: _____

Phone: _____ Email (optional): _____

Give my permission for Dr. Carrie Jones to take notes about me, including health history, medical, and/or personal information I choose to disclose to her.

I understand that this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC.

I also understand that this information will anonymously be used for the Arvigo Institute, LLC, for statistical purposes, and that Dr. Carrie Jones may use this information to provide me with a summary for my own personal use.

Signature: _____ Date: _____

Name (print) _____