910 W Main St. Suite 320 www.pulseholistichealth.com 208.955.8272

NEW CLIENT INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone:_____ Work or Cell Phone: _____

D.O.B.: _____ Height: _____ Weight: _____ Marital Status: _____ M / F

Occupation: _____ Referred by: _____

MAJOR COMPLAINT

What is your primary reason for this visit? _____

_____

_____

Any medical conditions we should be aware of? _____

_____

_____

List any medications or supplements you are currently taking:

_____

_____

_____

Signature: _____ **Date**: _____

How did you hear about us? **Internet** **Yellow Pages** **Flyer** **Newspaper**

Referral: _____ **Other:** _____

Ask about our referral program!

Pulse Holistic Health has a monthly email newsletter. Would you be interested in receiving it? **YES** **NO**

Would you be interested in being sent occasional newsletters via the post office? **YES** **NO**

FAMILY HISTORY

Father—Alive/Deceased. Present health or cause of death: _____
Mother—Alive/Deceased. Present health or cause of death: _____
Brothers and/or Sisters—No. Alive _____ No. Deceased _____
Present health or cause of death: _____
Children—No. alive _____ No. Deceased _____
Present health or cause of death: _____

Circle illnesses which have occurred in any of your blood relatives:

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis Obesity Heart disease
High blood pressure Nervous illness Allergy Alcoholism Mental illness Stroke
Other: _____

PERSONAL MEDICAL HISTORY

Describe your health as a child: _____
_____

Circle illnesses or conditions you have or had in the past:

Diabetes Glaucoma Heart trouble High blood pressure Syphilis Vein trouble Cancer
Asthma Jaundice Gonorrhea Bleeding tendencies Tuberculosis Mumps Pneumonia
Allergies Kidney disease Rheumatic fever Nervous disorder Measles Chicken pox HIV
Meningitis Multiple sclerosis Mononucleosis High fevers Antibiotic use Hepatitis Polio
Other: _____
List illnesses and date requiring surgery: _____
_____
Any other serious injury, broken bones, scars, etc? _____
_____
Are you pregnant? yes / no How many months? _____
Circle immunizations that you have received:
Smallpox Tetanus Typhoid Influenza Polio Other: _____
Have you ever taken cortisone type drugs? _____
Please list date of last physical: _____ Cholesterol test: _____
HIV test: _____ Prostate test: _____
Pap Smear: _____ Mammography: _____
Blood tests (which?): _____
Test results: _____
_____
Are you currently receiving care from a: ____ Chiropractor ____ Acupuncturist ____ Medical
____ Dentist ____ Physical Therapist ____ Massage Therapist ____ Nutritionist

COMMENTS (anything else you would like to tell us):

_____
_____
_____
_____
_____
_____
_____
_____
_____

CHECK ALL THAT APPLY:

GENERAL
___ fatigue
___ sleep problems
___ swollen glands
___ hot or cold intolerance
___ frequent headaches
___ weight loss / gain
___ fever or chills
___ allergies
___ nervousness
___ depressed
___ irritable

NERVOUS SYSTEM
___ dizziness
___ blurred vision
___ fainting
___ paralysis
___ tremors
___ numbness/tingling
___ convulsions
___ imbalance
___ memory loss
___ muscle weakness

NECK
___ pain in neck
___ neck pain w/movement
___ pinched nerve in neck
___ neck feels out of place
___ stiff neck
___ muscle spasms in neck
___ popping sounds in neck
___ arthritis in neck

HEAD
headache: note which area
- ___ entire head
- ___ back of head
- ___ forehead
- ___ temples
- ___ migraine

___ head feels heavy
___ loss of memory
___ light-headedness
___ fainting
___ light bothers eyes
___ loss of smell
___ loss of taste
___ loss of balance
___ dizziness
___ loss of hearing
___ pain in ears
___ buzzing in ears

ENT
___ earache
___ ear discharge
___ ringing in ears
___ hearing loss
___ nosebleeds
___ hoarseness
___ problems swallowing
___ sore throat
___ jaw tight or sore
___ dental problems
___ glasses/contacts

EMOTIONAL
___ anxiety or worry
___ frequent crying
___ anger
___ tension
___ mood swings
___ fear
___ restlessness
___ confusion
___ depression
___ suicidal

CHEST
___ chest pain
___ shortness of breath
___ pain around ribs

MID BACK
___ mid back pain
___ pain between shoulder blades
___ sharp stabbing pain
___ muscle spasms

LOW BACK
___low back pain
___Worse when
- ___ working
- ___ lifting
- ___ stooping
- ___ standing
- ___ sitting
- ___ bending
- ___ coughing

___ pinched nerve in low back
___ slipped disk
___ low back feels out of place
___ muscle spasms
___arthritis

SHOULDERS
___ pain in shoulder joints
___ pain across shoulders
___ bursitis (R / L)
___ arthritis (R / L)
___ can't raise arm
___ tension in shoulders
___ pinched nerve in shoulder
___ muscle spasms in shoulders

ARMS & HANDS
___ pain in upper arm
___ pain in forearm
___ pain in hands
___ pain in fingers
___ pinched nerve in arm
___ pinched nerve in fingers
___ pins & needles in arms
___ pins & needles in fingers
___ finger go to sleep
___ hands cold
___ swollen joints in fingers
___ arthritis in fingers
___ loss of grip strength

HIPS, LEGS & FEET
___ pain in buttock (R / L)
___ pain in hip joint (R / L)
___ pain down leg (R / L)
___ leg cramps
___ pins & needles in legs
___ numbness in legs (R / L)
___ numbness in feet (R / L)
___ numbness in toes
___ feet feel cold
___ cramps in feet (R / L)
___ swollen ankles (R / L)
___ swollen feet (R / L)
___ painful joints in toes
___ pain in feet (R / L)
___ pain in knee (R / L)

MUSCULOSKELETAL
___ joint swelling
___ muscle cramps
___ neck pain
___ shoulder pain
___ tennis elbow
___ arm pain
___ hand sensations
___ loss of grip
___ mid-back pain
___ rib pain
___ low back problems
___ hip pain
___ foot problems
___ leg cramps
___ knee pain
___ ankle weakness
___ tingling foot

SKIN
___ easy bruising
___ dry skin
___ itching
___ boils
___ rashes
___ excessive sweat
___ hair changes

HEART/LUNG
___ chest pain
___ high blood pressure
___ low blood pressure
___ persistent cough
___ hard to breathe
___ coughing blood
___ coughing phlegm
___ irregular heartbeat
___ varicose veins
___ ankle swelling

GASTROINTESTINAL
___ change in appetite
___ thirst
___ nausea
___ vomiting
___ diarrhea
___ constipation
___ gas
___ hemorrhoids
___ gall bladder
___ belching
___ heartburn
___ abdominal pain
___ bloody/black stools
___ indigestion
___ liver trouble

REPRODUCTIVE SYSTEM
___ painful intercourse
___ prostate problems
___ sexual problems
___ loss of sex drive
___ genital infections
Birth control method _____

WOMEN ONLY
___ cramps
___ PMS
___ irregular periods
___ pregnant

date of last period _____
# of pregnancies _____
# of miscarriages _____
# of abortions _____
___ difficult labor
___breast problems

NUTRITIONAL EVALUATION
List some of your favorite foods: _____
_____

Do you skip meals? yes / no If so which meal? _____
How many meals a day do you eat? _____ When is your biggest meal? _____
Do you eat when you are worried or rushed? yes / no How often? _____
DO YOU:

eat raw fruits or vegetables at least twice a day? yes / no
eat green or yellow vegetables at least twice a day? yes / no
eat frequently between meals? yes / no
chew your food thoroughly before swallowing it? yes / no
drink juice, milk, or other drinks instead of water when thirsty? yes / no
always add salt at the table? yes / no
eat meat or dairy products 2 or more times a day? yes / no
eat the same foods almost every day? yes / no
eat when you're not hungry? yes / no
eat until you feel full? yes / no
occasionally go on a "crash" diet? yes / no
always buy the cheapest foods? yes / no

Check the types of foods you normally eat on any given day:

___ artificially colored or sweetened drinks
___ deserts
___ white flour
___ food made with sugar
___ foods w/ chemical additives
___ processed, treated meats
___ commercial (non-organic) meats
___ dairy products (pasteurized / processed)
___ commercial canned fruits & veggies
___ commercial frozen fruits & veggies
___ commercial nuts
___ sugar substitutes
which brand _____
___ fried foods
___ packaged foods (rice-a-roni, mac-n-cheese)
___ products w/wheat
___ organic, natural meats
___ organic dairy products
___ home canned fruits & veggies
___ 100% grain products
___ organic frozen fruits & veggies
___ organic fresh fruits & veggies
___ sprouts
___ organic nuts
___ natural sugar
___ juices

Do you use:

Alcohol? yes / no Amount per week: _____ Type: _____
Tobacco? yes / no Amount per week: _____ Type: _____
Coffee? yes / no Amount per week: _____ Type: _____
Carbonated drinks? (pepsi, coke, etc.) yes / no Per day: _____

How many glasses of water do you drink a day? _____ (filtered / bottles)
Do you react to any chemicals, cosmetics, household cleaners, smoke, fabrics, etc? _____
If yes please list: _____

Check any of the following items you are exposed to or use:

___ Aluminum cookware
___ Teflon cookware
___ Microwave oven
___ Computer terminal
Hours per day: _____
___ Fluorescent lights
Hours per day: _____
___ Synthetic fibers
___ Heavy metals (lead, mercury, asbestos,)
___ Toxic chemicals
___ Electric blanket
___ Secondhand cigarette smoke
___ Periodic high noise levels
___ Recreational, prescription, or over the counter drugs/medications

If yes please list and how often: _____

Do you live near:

___ A freeway or busy street
___ Major power line or electric substation
___ Radio or TV transmission tower
___ Toxic waste site
___ Airport
___ Nuclear reactor
___ Major industry
What kind? _____

Do you like your neighborhood? _____

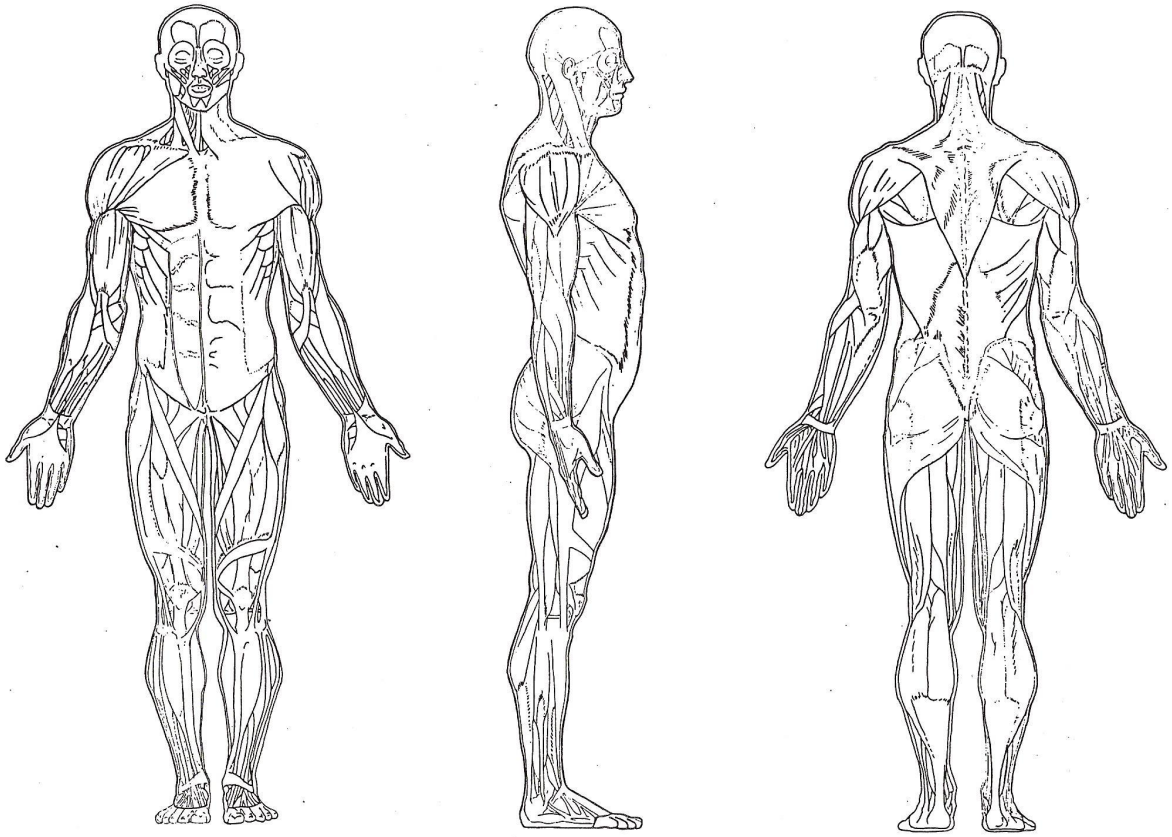
Is your home:

Heated with: ___ Electricity ___ Gas ___Wood Other: _____
___ Hot___Cold ___ Light ___ Dark ___ Drafty ___Damp ___Relaxing
___ Tense ___ New ___ Old___Safe ___ Noise
___ Recently remodeledOther: _____

LIFESTYLE EVALUATION

Work; _____ Position held: _____
How long? _____ Do you like your job? _____
Do you have any problems? _____ If yes, what? _____
Do you have financial worries? _____
Highest level of education: _____
What are your hobbies/interests? _____
How many hours per day do you watch TV? _____ Favorite shows? _____
Do you have stress in your life? _____
If yes, what causes the stress? _____
Is your energy level: ___ high ___ low ___ up and down
Do you exercise? _____ If yes, how many hours a week? _____
___ outdoors ___ indoors ___ Regularly ___ Occasionally ___ Never
How many hours do you sleep at night? _____ Usual bedtime: _____
Usual time you get up? _____ Do you feel rested when you get up? _____
How often do you take naps? _____ How often do you wake up at night? _____
How long have you been with your spouse? _____ Companion? _____
Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (i.e. divorce, injury, death in family, change in residence, bankruptcy, etc.) _____
_____
What is the most important health change you would like to occur? _____
_____
How do you feel about yourself? ___ very good ___good ___ fair ___ not good
What would you like to change about yourself? _____
How many hours do you spend alone? _____ do you enjoy being alone? _____
What is your religious upbringing? _____
Religious faith now? _____
What is your religious practice? ___ prayer ___ meditation other _____
How often? _____ Is it important to you? _____

PLEASE MARK YOUR AREAS OF PAIN



Informed Consent and HIPPA Compliance
You understand that the practitioners of Pulse are not medical doctors and that the therapy suggestions made are in no way meant to replace conventional medicine or treatment when necessary_____ (initial)

By signing below you acknowledge that you have been given the opportunity to review Pulse's posted Privacy Policy (HIPPA).

_____ _____
(signature) (date)

Root Chakra
1.Are you disorganized? Y or N
2.Do you eat, drink or smoke excessively as a means of escape? Y or N
3.Did you have some trauma, distress, or difficulty between conception and the age of 7? Y or N
4.Do you feel fearful or anxious much of the time? Y or N
5.Are you low in energy and often feel weak, tired, or just not well? Y or N
6.Do you have any physical problems in your legs, knees, or feet? Y or N

Sacral Chakra
1.Do you have difficulty with touch – either being touched gently or being able to touch others? Y or N
2.Do you have problems with your kidneys, bladder, or with retaining fluid? Y or N
3.Did you suffer distress or trauma between the ages of 7 and 14? Y or N
4.Do you feel that your general vitality and stamina are low? Y or N
5.Do you have difficulties with any part of your sexuality? Y or N
6.Do you feel your creativity is blocked or that you are not a creative person? Y or N

Solar Plexus Chakra
1.Do you have digestive problems, e.g. ulcers, heartburn, or recurrent indigestion? Y or N
2.Do you have an aggressive nature? Y or N
3.Did you suffer distress or trauma between the ages of 14 and 21? Y or N
4.Are you easily influenced? Y or N
5.Do you sometimes feel powerless or have low self-esteem? Y or N

Heart Chakra
1.Do you find it difficult to love or feel loved? Y or N
2.Are you intolerant, critical, judgmental? Y or N
3.Do you feel exhausted/drained most of the time? Y or N
4.Are you impatient or the opposite, i.e. so patient and tolerant that people take advantage of you? Y or N
5.Do you have difficulty in saying you are sorry or in feeling forgiveness? Y or N

Throat Chakra
1.Do you have difficulty with general communication? Y or N
2.Do you have problems expressing yourself with speech, with making yourself understood clearly? Y or N
3.Do you have problems listening attentively to other people's point of view? Y or N
4.Do you have problems with throat infections, thyroid, ears, or neck problems in general? Y or N
5.Are you shy, quiet, withdrawn? Y or N

Third Eye Chakra
1.Do you suffer from migraines, vision problems, or headaches? Y or N
2.Are you unable to visualize your future? Y or N
3.Do you have nightmares? Y or N
4.Do you have a lack of imagination? Y or N
5.Do you have difficulty concentrating? Y or N

Crown Chakra
1.Do you feel separated from abundance and wholeness? Y or N
2.Do you have difficulty learning new things? Y or N
3.Do you feel uncertain or feel a lack of purpose? Y or N
4.Do you have a fear of death? Y or N
5.Are you overly intellectual? Y or N