NEW CLIENT INTAKE FORM

First Name _____ Last Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work/Cell Phone _____

Email _____ Age _____ Height _____

Weight _____ D.O.B. _____ Occupation _____

Gender:_____ Relationship Status: _____

Please tell us what your primary health concerns are:

_____

_____

Please list current medications you are taking:

_____

_____

Please list current supplements you are taking:

_____

_____

Please list any allergies:

_____

_____

Describe your health as a child:

_____

_____

Please describe your current level of physical activity and exercise

_____

_____

Have you ever received Bodywork? (Amma, Shiatsu, Swedish, Deep Tissue, etc…)

_____

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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? _____

Are you currently receiving care from another healthcare practitioner? Modality?

_____

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: _____

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

_____

_____

Who can we thank for the referral _____

You understand that the practitioners of Pulse are not medical doctors and that the therapy and suggestions made are in no way meant to replace conventional medicine or treatment when and if necessary. _____
Initial

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

_____ _____
Signature Date

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NEW CLIENT INTAKE FORM

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**

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