Mindful Wellness

# New Client Intake Form

Client Name: _____ DOB:_____

Address:_____

Phone: Cell_____ Home_____ Work_____

Do we have permission to contact you via text on your cell phone YES_____ NO_____

Email Address: _____

Do we have permission to contact you via e-mail YES_____ NO_____

Legal Guardian: _____
*(If patient is a minor)*

Occupation: _____School/Grade*(If applicable)*: _____

Emergency Contact: _____ Phone:_____

Past Medical History (Please list any illness/diagnosis, physical injury, head injury – brain injury/concussion/whiplash/falls, surgeries): _____

_____

_____

_____

**MEDICATIONS (please include supplements): IF NONE WRITE N/A_____**

| NAME | DOSE | REASON FOR TAKING |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

Are you sensitive to any medication?_____

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**ALLERGIES (please list medication and food allergies): IF NONE WRITE N/A_____**

| MEDICATION | FOOD | REACTION |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |
| 6) | | |

**FAMILY HISTORY (G = grandparents, P = parents, S = self):**

**IF NONE WRITE N/A_____**

| | | |
|---|---|---|
| Cancer G P S | Thyroid G P S | Mental illness G P S |
| Heart disease G P S | Diabetes G P S | |
| Lung disease G P S | Autoimmune G P S | |

Other (please describe): _____

**SOCIAL HISTORY (Y = yes, N = no, P = past):**

| | | |
|---|---|---|
| Alcohol Y N P | Antacids Y N P | Addiction Y N P |
| Smoking Y N P | Laxatives Y N P | |
| Steroids Y N P | Pain meds Y N P | |

Addiction treatment(s):_____

**EMOTIONAL HISTORY (Y = yes, N = No, P = past):**

| | | |
|---|---|---|
| Anxiety Y N P | Anger Y N P | Panic Y N P |
| Depression Y N P | Irritability Y N P | Abuse history Y N P |
| Insomnia Y N P | High strung Y N P | Food addiction Y N P |
| Suicidal Y N P | Fear Y N P | Eating disorder Y N P |
| PTSD Y N P | Guilt Y N P | OCD Y N P |

Additional comments: _____


## REVIEW OF SYMPTOMS:

### PAIN: IF NONE WRITE N/A_____

Headaches:
How often? _____
Location? _____
Severity? _____
History of Migraine headache? Yes No
Triggers: _____

Body/joint/limb pain? Please describe: _____
Fibromyalgia? Yes No
Photophobia (sensitivity to light)? Yes No
Hyperacusis (sensitivity to/pain from sound)? Yes No
What makes your pain better? _____
What makes your pain worse?_____

### SLEEP: IF NONE WRITE N/A_____

Do you have difficulty falling asleep? Yes No
Do you have difficulty staying asleep? Yes No
How many hours do you sleep per night? _____
How many hours' sleep do you need? _____
Do you wake feeling rested? Yes No
Nightmares? Yes No

### FOCUS/CONCENTRATION/MEMORY: IF NONE WRITE N/A_____

ADD/ADHD? Yes No Medication/Treatment: _____
Poor concentration? Yes No
Impulsivity? Yes No
Difficulty making decisions? Yes No
Easily distracted? Yes No
Racing thoughts? Yes No
Disorganized? Yes No
Overwhelmed by stimuli? Yes No


**NEUROLOGICAL: IF NONE WRITE N/A_____**

Seizures? Yes No Type: _____
Stroke? Yes No Location: _____
Tremors? Yes No
Traumatic Brain Injury? Yes No
Vertigo? Yes No
Tinnitus (ringing in the ears)? Yes No
Hearing loss? Yes No
Poor balance? Yes No

**IMMUNE/ENDOCRINE/AUTONOMIC NERVOUS SYSTEM:**
**IF NONE WRITE N/A_____**

Immune deficiency? Yes No
Adrenal insufficiency? Yes No
Chronic Fatigue Syndrome? Yes No
Multiple Chemical Sensitivities? Yes No
Asthma? Yes No
Irregular Menstrual Periods? Yes No
Premenstrual Syndrome (PMS)? Yes No
Menopause? Yes No
Constipation? Yes No

Additional comments: _____

**Most prominent symptoms you would like to focus on with the IASIS MCN Treatments:**

_____ _____
_____ _____
_____ _____

Patient Signature_____ Date_____