



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: _____

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:

FEMALE ~ REPRODUCTIVE HEALTH HISTORY

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

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

Termination(s): _____ When? _____

Miscarriage(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, patch, 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)

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) _____



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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) _____