Naturally Well

3001 Northridge Drive Suite 7
Farmington, NM 87401
(505) 320-4704 Cell
E-mail: carrievallejos@gmail.

Client Health Intake Form

Name_____Birth date_____Age_____Sex_____

Address_____City_____State_____Zip_____

Telephone (Cell)_____Telephone (work)_____Email_____

Referred by:_____Address_____

In emergency notify_____Telephone_____

Have you received therapeutic massage / bodywork before? Yes_____No_____

I understand that the therapeutic bodywork given here at Naturally Well is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that the bodywork therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the bodywork therapist does not prescribe medical treatment or pharmaceuticals. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a medical doctor for any ailment that I might have. No guarantees or warranties are implied or expressed with the bodywork treatments that are given here.

Since a bodywork therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the bodywork therapist updated on my physical health.

_____ _____

Client Signature Date

Main problem you would like us to help you with._____

How long ago did this problem begin?_____

Have you been given a diagnosis for this problem?_____If so what?_____

What types of treatments have you tried?_____

Are you currently receiving treatment for your problem?_____

If so, please describe:_____

Does anything improve your problem?_____

Past Medical History (please include dates):

Illnesses:_____

_____

Surgeries:_____

_____

Significant Trauma (auto accidents, falls, etc.):_____

_____

Do you have, or have you ever had, any infectious diseases?_____

If so, please describe:_____

Medicines: (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months.)
_____
_____
Average or typical blood pressure_____/_____ Pulse rate_____
Allergies:_____
_____

Please describe your average daily diet:

Morning	Afternoon	Evening
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

% raw food _____to cooked_____Are you on a restricted diet?_____ Describe?_____
Do you have any cravings?_____If so, what?_____When?_____
Preferred tastes: Bitter_____ Spicy_____ Sour_____ Salty_____ Sweet_____
_____

How many packs of cigarettes do you smoke a day?_____ I cook in: Teflon__ Aluminum__ Steel__ Ceramic__
How much do you drink per day? alcohol _____ soda_____ coffee_____ tea_____

How much water do you drink per day? ____What type of water do you drink? tap___ RO___filtered___ bottled__

Do you use food containing: conola__soy__margarne__arificial sweetners__sugar-free products___low fat___

Do you spend time in the sun?_____ How much? _____ Do you use sunblock?_____

Do you take an antacid?_____ What % of fat in milk to you use? _____

Do you have dentures? _____ top ____ bottom ____ How many root canals? ____ Which teeth? _____

I buy: processed foods ___ fresh commercial produce___ organic produce___ organic meats ___green cleaners__

_____

Family Medical History (General Health):

Mother's side: _____
Father's side: _____
Siblings:_____
If above deceased, cause of death: _____

Personal Health History:

Birth (prolonged labor, forceps delivery, etc.)_____
State of childhood health:_____
Location of upbringing: _____
Current emotional health:_____Current quality of life:_____
Current relationship quality:_____ Current predominant emotion:_____
Occupation:_____Have you had any unusual stresses recently?_____
Favorite time of year:_____
Hobbies and Recreational habits:_____
Do you have a regular exercise program:_____Please describe:_____
Travel abroad within the past year?_____ Where?_____

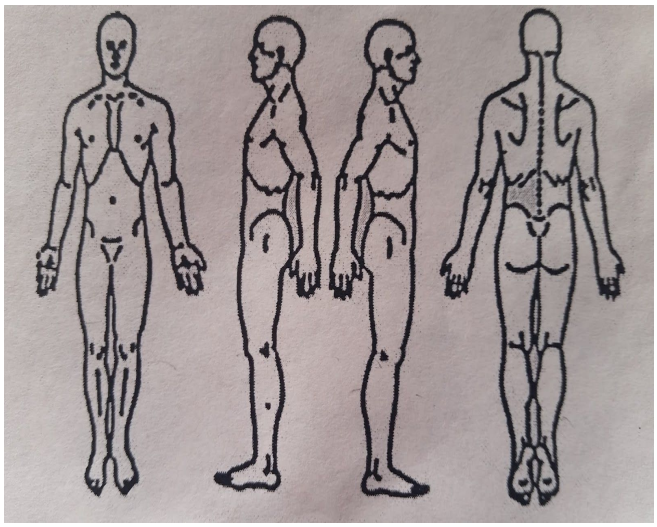
Check any of the below if you have experienced it within the last three months:

General: ❑ Fevers ❑ Chills ❑ Fatigue ❑ Poor sleep/insomnia ❑ Dream disturbed sleep ❑ Depression ❑ Mania ❑ Emotional changes ❑ Tremors	❑ Seizures ❑ Night sweats ❑ Day sweating ❑ Poor balanced ❑ Weight loss ❑ Weight gain ❑ Poor appetite ❑ Change in appetite ❑ Peculiar tastes or smells	❑ Sudden energy drops ❑ _____what time of day ❑ Headaches ❑ Localized weakness ❑ Bleeding or bruising ❑ Joint pain ❑ Strong thirst ❑ For hot drinks ❑ For cold drinks
Cardiovascular: ❑ High blood pressure ❑ Irregular heartbeat ❑ Low blood pressure ❑ Chest pain ❑ Dizziness	❑ Fainting ❑ Cold sweats ❑ Swelling of feet ❑ Swelling of hands ❑ Difficulty in breathing	❑ Cold hands or feet ❑ Phlebitis ❑ Blood clots ❑ Palpitations
Respiratory: ❑ Cough ❑ Asthma ❑ Bronchitis ❑ Pain with deep breaths	❑ Difficulty in breathing ❑ When laying down ❑ Easily winded with exertion ❑ Shortness of breath	❑ Coughing blood ❑ Production of phlegm ❑ What color?_____
Gastrointestinal: ❑ Nausea ❑ Vomiting ❑ Indigestion ❑ Ulcers ❑ Abdominal pain or cramps	❑ Parasites ❑ Belching ❑ Bad breath ❑ Digestive disorders ❑ constipation	❑ Diarrhea ❑ Blood in stools ❑ Hernia ❑ hemorrhoids
Genito-urinary: ❑ Pain on urination ❑ Urgent urination ❑ Frequent urination ❑ Unable to hold urine	❑ Decrease in urine ❑ Blood in urine ❑ impotency/infertility ❑ Genital sores	❑ Kidney stones ❑ Waking up to urinate ❑ How often?_____
Musculo-skeletal: ❑ General aches ❑ Muscular atrophy ❑ Muscular weakness ❑ arthritis	❑ Joint instability ❑ Muscle cramps ❑ Spasms ❑ Recent sprains	❑ Injuries or falls ❑ How many?_____ ❑ Breaks ❑ Where?_____ ❑ _____

On the diagrams to the side, please mark an “X” over those areas of concern. Indicate old or new. Also, if it is a place of Tension or pain, mark it.

Are there any other internal organ or systemic dysfunctions that we should be aware of?

_____
_____
_____
_____



Ear, Nose & Throat ❑ Ringing in ears ❑ Poor hearing ❑ Earaches ❑ Sinus problems Any other ear, nose & throat problems?_____ _____	❑ Nose bleeds ❑ Recurrent sore throat ❑ Sores on lips or tongue ❑ Teeth problems	❑ Grinding teeth ❑ Facial pain ❑ Jaw clicks
Eyes & Vision ❑ Glasses ❑ Poor vision ❑ Blurred vision ❑ Cataracts Any other eye problems?_____ _____	❑ Glaucoma ❑ Eye strain ❑ Eye pain ❑ Color blindness	❑ Night blindness ❑ Floaters ❑ Spots in front of eyes
Skin & Hair ❑ Rashes ❑ Itching ❑ Eczema ❑ Ulcerations Any other hair or skin problems?_____ _____	❑ Hives ❑ Pimples ❑ Recent moles ❑ Dandruff	❑ Loss of hair ❑ Change in hair ❑ Change in skin texture
Neuro-Psychological: ❑ Seizures ❑ Concussion ❑ Dizziness ❑ Headaches ❑ Migraines ❑ Areas of numbness ❑ Treated for emotional problems Any other neurological or psychological problems?_____ _____	❑ Lack of coordination ❑ Loss of balance ❑ Fainting ❑ Disorientation ❑ Irritability ❑ Easily susceptible to stress ❑ Considered or attempted suicide	❑ Easily angered ❑ Depression ❑ Mania ❑ Anxiety ❑ Poor memory ❑ Nervous habits
Pregnancy & Gynecology: _____age at first menses _____period between menses _____duration of menses _____first date of last menses _____usual character of menses ❑ Heay ❑ Light ❑ Irregular periods ❑ Painful periods	_____number of pregnancies _____number of births _____miscarriages _____abortions _____difficult births	❑ Breast lumps ❑ Birth control ❑ _____what type ❑ _____how long ❑ Fertility problems ❑ Vaginal discharge ❑ Clots ❑ Vaginal sore ❑ _____last pap smear

Please tell us of any other problems you would like to discuss;_____

_____

_____

_____

_____

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly

- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such **Notice of Privacy Practices.** I understand that my provider has the right to change the **Notice of Privacy Practices** and that I may contact the holistic therapy clinic to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that the holistic massage therapist restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that the holistic massage therapist is not required to agree to my requested restrictions, but if the holistic massage therapist agrees then we are bound to abide by such restrictions.

Patient's Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

Dependent family member also covered by this acknowledgement:_____

I have been informed of the holistic massage therapist revised **Notice of Privacy Practices** on the following dates:

Date:_____ Signature:_____

Date:_____ Signature:_____

We were unable to obtain the client's written acknowledgement of our Notice of Privacy Rights due to the following reasons:

- ❏ The patient refused to sign
- ❏ Communication barriers
- ❏ Emergency situation
- ❏ Other

Disclaimer Form

I understand that the therapeutic bodywork given here is provided by a licensed massage therapist who is licensed by the state of New Mexico. This treatment is complementary to health care services provided by licensed healthcare practitioners.

The therapist may use nutrition, herbs, homeopathics, hydrotherapy or therapeutic bodywork to provide the clients with relaxed muscles; relief of pain and stiffness from tension, cramps and spasms; prevent muscle atrophy; lower blood pressure; stimulate blood and lymph circulation; aid in elimination of toxins and wastes; increase nutrition to cells; expand physical, emotional and mental, and spiritual awareness; and facilitate the healing of injuries. I understand that the bodywork therapist here is a licensed massage therapist and unlicensed traditional naturopath trained in hydrotherapies, herbology, homeopaths, nutrition, and therapeutic bodywork. As such, they do not diagnose illness, disease or any other physical or mental disorder.

The body work therapist does not prescribe medical treatment of pharmaceuticals. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a medical doctor for any ailment that I might have. No guarantees or warranties are implied or expressed with the bodywork treatments that are given here.

Because a bodywork therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the bodywork therapist updated on my physical health.

As a patient, I have the right to complete a current information concerning the practitioner's assessment and recommended services that are provided, including the expected duration of the services to be provided, the method of billing for the fees listed below, that I have the right to reasonable notice of changes in services and/or charges, and that I be allowed access to my record and any written information from my records. All my records and transactions are confidential unless the release of these records are authorized in writing by me or otherwise provided by law. I have the right to a coordinated transfer when there is a change in the therapist.

I understand that I may file complaints with the:

New Mexico Massage Therapy Board
2550 Cerrillos Road
Santa Fe, New Mexico
(505) 476-4870

My signature below acknowledges this information.

X_____ _____

Client signature Date

Fee schedule:	First visit $60	Child 1-6 $25
	Returning patient $55	Child 7-12 $30
	Senior Citizen $50	Child 13-15 $35