Confidential Intake Form

Date of Initial Visit: _____

Name: _____

Address_____

State _____ Zip _____Home Phone_____

Work Phone_____Cell_____Email_____

Date of Birth _____ Age _____

Female _____ Male_____ Other_____ Preferred Pronoun_____

Occupation_____

Marital/Relationship status _____ Referred by_____

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I am aware that if I cancel **the day before my appointment**, Mujo Wellness charges **50%**. If I cancel **the day of my appointment or don't show** for my scheduled appointment time, I will be charged **100%**. I agree that both cancellation and no-show fees will be paid within 24 hours of the appointment.

Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Practitioner signature_____Date:_____

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Reason for Visit

Primary reason for visit: _____

When did your 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** _____

Have you had massage/bodywork before? _____

What type of pressure do you prefer (circle): Light Medium Firm

Do you light heat on the table (circle): YES NO

Medical History

Are you currently under the care of another health care provider(s)? _____ **Reason(s)** _____

_____

Name of Provider: _____ **Address:** _____

Phone: _____**Email:** _____

Current Medications and/or Supplements/Remedies: _____

_____

Allergies: (specify allergen and reaction): _____

Surgical History (year and type) and/or Recent Procedures: _____

_____

Hospitalizations: _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

Other: _____

Please review and check the following:

Headaches Type:	**Past: Present:**	**Numbness in feet or legs when standing**	**Past: Present:**
Asthma		**Sore heels when walking**	
Cold Hands or feet		**Anxiety**	
Swollen ankles		**Depression**	
Sinus Conditions Frequent Colds		**Sleep Disturbance**	
Seizures		**Fainting Spells**	
Low Back Pain		**Muscular Tension: Location:**	
Skin Disorders: Type		**Varicose Veins Hemorrhoids Location**	
Sciatica		**Herniated/Bulging Discs**	
Painful/Swollen Joints		**Artificial/Missing limbs**	
High or Low Blood Pressure		**Contact Lenses**	
Dentures/Partials		**Cancer (type, past or current)**	

Other (not mentioned above): _____

Family History

	Still Living?	**Cause of Death and Age**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____Water Intake (glasses/day) _____Caffeine_____

Do you use Tobacco? _____ Quantity_____/ppd Alcohol? _____ Quantity _____ounces/day

Marijuana? _____Quantity _____Other: ___ Have you been under treatment for substance use? _____

Food Allergies: _____

Do you experience bloating/gas/burps after eating? _____

What is the cause (stress, specific foods, time of day, etc.): _____

Are you subject to binge-eating: _____

How often are your bowel movements? _____ Constipation? _____

Diarrhea? _____ Pain when stooling? _____ Other: _____

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: _____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment?

_____

Describe your exercise routine (type, frequency): _____

Reproductive Health History - Female Anatomy

Last Pap smear _____ Results (if known) _____

Are you under the treatment for Infertility _____Describe current treatment to date: _____

(IUI, IVF, etc.)_____

Gynecological Provider: _____Address_____Phone_____

Menstrual History Review:

Age of Menses: _____What was this like for you? _____

Last Menstrual Period: _____Length of Menses_____

Method of Contraception (circle) Pills Patch Diaphragm Injection Condoms IUD Abstinence

Rhythm Method Fertility Awareness Other: _____

Length of time using method: _____

Are you trying to conceive? _____ Possibility of Pregnancy_____

Painful Periods	**Past Present**	**Irregular cycles Early Late**	**Past Present**
Heaviness in Pelvis prior to menses		**Dark Thick Blood at: Beginning End Both**	
Excessive Bleeding Pads per Hour		**Headache or Migraine with menses**	
Dizziness		**Bloating**	
Water Retention		**Ovulation: Painful Failure to**	
Endometriosis Location (if known)		**Fibroids Location (if known)**	
Uterine or Cervical Polyps		**Uterine Infection(s)**	
Vaginal Infection(s)		**Cysts Location:**	
Bladder Infection(s)		**Urinary Incontinence**	
Painful Intercourse		**Vaginal Dryness**	
Episodes of Amenorrhea How long?			

Pregnancy History:

Number of Pregnancies: **Number of Births:** **Dates:**	**Complications:**	**Miscarriages:**	**Terminations:**
Premature Births:	**Spotting during Pregnancy**	**Weak Newborns at Birth**	**Incompetent Cervix**

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing_____

Post-Partum: _____

Maternal Family History (*please circle*): Infertility Fibroids Endometriosis PMS Menopause

Cancer (type) _____Menstrual Problems _____ Other_____

Medications your mother took when she was pregnant with you (if any): _____

Your Birth Trauma (if known): _____

Other:

Rate your interest in Sex: High_____ Moderate_____ Low_____ None_____

Do you have or ever had difficulty experiencing orgasms: _____

Do you have a history of rape: _____trauma: _____incest: ____ If so, when:_____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information: _____

Menopause

Age symptoms began: _____Are they getting worse _____better _____same _____

Are you on/ or ever been on hormone replacement therapy? _____if so, how long_____

Name and dose_____

Reason for stopping_____

Age of Mother at menopause: _____Concerns/Experience_____

Check the following symptoms that apply to you:

Hot flashes	**Insomnia**	**Fatigue**	**Memory Loss**	**Mood Swings**
Vaginal Discharge	**Dry Vagina**	**Depression**	**Anxiety**	**Irritability**
Spotting	**Flooding**	**Irregular Menses**	**Painful Intercourse**	**Increased Libido**
Decreased Libido	**Disturbed Sleep Pattern**			

Please feel free to share any additional information: _____

Reproductive Health History - Male Anatomy

Please check the symptoms below that apply:

Painful Urination	Past Present	Urinary Retention	Past Present
Urinary Incontinence or Dribbling		Difficult starting or holding urine stream	
Weak or Interrupted Urine flow		Blood or pus in urine	
Pain or Burning with Urination		Pelvic pressure	
Nocturnal Urination How many times?		Insatiable sex drive	
Pain in lower back, esp. After intercourse		Pain or Discomfort Between scrotum and Testicles	
Pain or Discomfort in: Penis Testicles Rectum		Pain or Discomfort in Inner thighs: Left Right Both	
Frequent Bladder or Kidney Infections When?		Erection: Difficulty in Obtaining Maintaining Painful ejaculation	

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known) _____Date done_____

Family History of Prostate Disease: Yes___No___Type_____Relationship_____

Family History of Cancer Yes____No_____Type_____Relationship_____

Sexually transmitted disease Yes ___No ___Type if Known_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have a history of rape _____trauma _____incest _____ If so, when? _____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information: _____