Serenity Health & Wellness Center
1685 Lance Pointe Drive
Maumee, Ohio 43537
(419) 891-2181
www.serenityhealthmaumee.com

Naturopathic Client Intake & Health Form

Last Name: ____________________________ First Name: _________________________

Address: _____________________________________ Postal Code:_________________

Primary Phone: _______________ Day Phone: _______________ Cell #: ___________________

Occupation: _________________ How did you hear about us?: ___________________________

Date of Birth:_________________ Email: ____

What is your 1st major condition you want to improve?
____
____
When did you first notice this? ____
What brought it on? ____
What activities aggravate the condition? ____
Is this condition getting progressively worse? ❑ Yes ❑ No
Please explain:
____
Does this condition interfere with:
Work? ❑ Yes ❑ No Sleep? ❑ Yes ❑ No Daily Routine? ❑ Yes ❑ No
Please explain:
____
What have you done to get relief? ____
Has there been a medical diagnosis? ❑ Yes ❑ No – Results _______________________________

What is your 2nd condition you wish to improve?
____
____
When did you first notice this? ____
What brought it on? ____
What activities aggravate the condition? ____
Is this condition getting progressively worse? ❑ Yes ❑ No
Please explain:
____

I UNDERSTAND THAT TRADTIONAL NDs DO NOT DIAGNOSE OR CURE DISEASE & THEY ARE NOT RESPONSIBLE OR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, SERVICES OR PRODUCTS. I UNDERSTAND I AM CHOOSING A NATUROPATHIC APPROACH AT MY OWN RISK.

Contact information for questions: Teresa Myers-734-846-2695 or tsa.myers@gmail.com

Does this condition interfere with:

Work? ❑ Yes ❑ No Sleep? ❑ Yes ❑ No Daily Routine? ❑ Yes ❑ No

Please explain:

___

What have you done to get relief? ___

Has there been a medical diagnosis? ❑ Yes ❑ No – Results ___

What are your intentions and expectations for this visit? ___

___

What other holistic therapies have you received? ❑ Massage ❑ Acupuncture ❑ Chiropractic

❑ Hypnotherapy ❑ Energy / Chakra Healing ❑ Shiatsu ❑ Bowen ❑ Reiki

❑ Physiotherapy ❑ Other (list) ___

Health History

Check the following conditions that apply to you, past and current.

Key: P = Past and C = Current

Please add your comments to clarify the condition.

General Conditions

❑ Fatigue
❑ Chronic Pain
Where___
❑ Excessive Cold
❑ Depression – How Long? ___

❑ Weakness
❑ Lack of Concentration
❑ Insomnia
❑ Headaches
❑ Cancer___
Treatments___

❑ Sensitivity to Light
❑ Contagious Disease
❑ Excessive Heat
❑ Migraines
❑ Other___

Comments:

___

Muscular / Skeletal

❑ Joint Stiffness / Swelling
❑ Dislocations
❑ Scoliosis
❑ Shoulder / Neck Pain

❑ Spasms / Cramps
❑ Tendonitis
❑ Osteoporosis
❑ Back Pain

❑ Strains / Sprains
❑ Bursitis
❑ Bone / Joint Disease
❑ Arm / Hand Pain

❑ Broken / Fractured Bones
❑ Arthritis
❑ Chest / Rib Pain
❑ Leg / Foot Pain
❑ Other___

Comments:

___

Neurological / Throat /Skin

❑ Dizziness
❑ Ringing in ears
❑ Psorias
❑ Throat infections
❑ Warts

❑ Concussions - # ___
❑ Head Trauma
❑ Acne
❑ Cosmetic Surgery
❑ Abnormal Moles

❑ Eye / Vision problems
❑ Skin Sensitivities
❑ TMJ/Jaw problems
❑ Rashes
❑ Other___

❑ Poor hearing
❑ Eczema
❑ Grinding teeth
❑ Athlete's Foot

Comments:

___

Cardiovascular

❑ High Blood Pressure
❑ Chest pain
❑ Fainting
❑ Lymphedema
❑ Anemia

❑ Low Blood Pressure
❑ Irregular heart beat
❑ Dizziness
❑ Varicose veins

❑ Pace maker
❑ Bruise / Bleed easily
❑ Sweats / Chills / Fever
❑ Heart Condition

❑ Diabetes
❑ Blood Clots
❑ Stroke___
❑ Other ___

Comments:

___

Respiratory

- ❑ Asthma
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Lung Cancer
- ❑ Pneumonia
- ❑ Sinus Discomfort
- ❑ Excess Mucous
- ❑ Allergies _____________
- ❑ Other _______________

Comments:

____

Digestive and Uro-Genital

- ❑ Liver / Gall Bladder
- ❑ Gall stones
- ❑ Kidney
- ❑ Kidney stones
- ❑ Venereal disease
- ❑ Abdominal Pain
- ❑ Indigestion / Reflux
- ❑ Excess Gas / Bloating
- ❑ Colitis
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Adaptive Aids
- ❑ Elimination #___Daily
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nervous Stomach
- ❑ Irritable Bowel
- ❑ Poor / Heavy Appetite
- ❑ Cravings ______________
- ❑ Urination # ____daily
- ❑ Urination Discomfort
- ❑ Bladder Infection
- ❑ Impotence
- ❑ Other ________________

Comments:

____

Gynecology

- ❑ Pregnant (# of months____)
- ❑ Miscarriages - # _____
- ❑ Menopause – Age ____
- ❑ PMS / Cramps
- ❑ Pelvic Inflammation
- ❑ Fertility Concerns
- ❑ Breast lumps/cysts
- ❑ Uterus cysts
- ❑ Endometriosis
- ❑ Hysterectomy – Date _____
- ❑ Other _________________

Comments:

____

Nervous System

- ❑ Spinal Injury
- ❑ Sciatica
- ❑ Fractures/Breaks of spine
- ❑ Herniated Disc
- ❑ Fibromyalgia
- ❑ Seizures / Epilepsy
- ❑ Tremors
- ❑ Parkinson's Disease
- ❑ Cerebral Palsy
- ❑ Stroke
- ❑ Numbness
- ❑ Twitching
- ❑ Tingling
- ❑ Paralysis – constant or Temporarily
- ❑ Muscular Dystrophy
- ❑ Multiple Sclerosis
- ❑ Neurological Conditions Type____________________
- ❑ Other______________

Comments:

____

Are you presently taking any medications, supplements, or herbs? (Please list and give reason)

____
____
____
____

Have you had any injuries, accidents or surgery? (Type, Date & Direction of impact if applicable)

1.____
2.____
3.____

What is your stress level? Slight ___ Moderate ___ High ____

What is the source(s) of your stress? ____

How do you relieve stress?

____
____

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What is your level of physical activity? ___ None ___ Low ___Moderate ___ High

What exercise do you do? How often?

____

____

What leisure activities do you enjoy?

____

____

What interests or hobbies do you have?

____

____

What gives meaning and purpose to your life?

____

____

Do you have a spiritual practice?

____

____

Whom do you live with?

____

____

Describe your home health environment:

Quiet _______ Noisy ______ Crowded ______ Supportive ______

Would change:

Comfort level:

Fluorescent lights ?________ Water type for drinking __________ Fluoridated water? ______

Pets? _______________ Do you have help with household duties? ____________________

What is your current or previous occupation?

____

How would you rate your satisfaction with your work? Use a scale 1 to 5 (5 being the highest level of satisfaction)

1-----------2---------3--------4-------5

Describe the health of your working environment: (chemical exposure, safety, sound, light, comfort, the pace, relationships, access to outdoors)

____

____

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VITALITY:

Fatigue: General _____ Chronic _____ Tired upon arising _______

Activity fatigues me _____ Exercise gives me energy______ Mental Fatigue _________

I feel I have vitality in the following areas:

Areas (physical, mental, emotional , spiritual) wherein I wish to improve my vitality:

SLEEP:

Sleep Quality: Insomnia ____ Restless sleep _____ Sleepy during day ____

Fall asleep, then wake up cannot go back _________ Pain keeps me awake ____________

Naps and rests -do you take them OR do you push through the day? _____________

Meditation? _____ /per week

TRAVEL:

Have you traveled out of the country in the last three years? _____yes _____no

If yes, where:____

DIETARY/NUTRITION:

Current Weight: _____________ Desired Weight (if different): __________

Maximum Weight: _____________ When? __________ Minimum Weight: _____________ When? __________

Have you gained or lost any weight in the past 6-12 months? Y N

If yes, how much? _________

Do you have any food allergies or intolerances? Please list.

____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

____

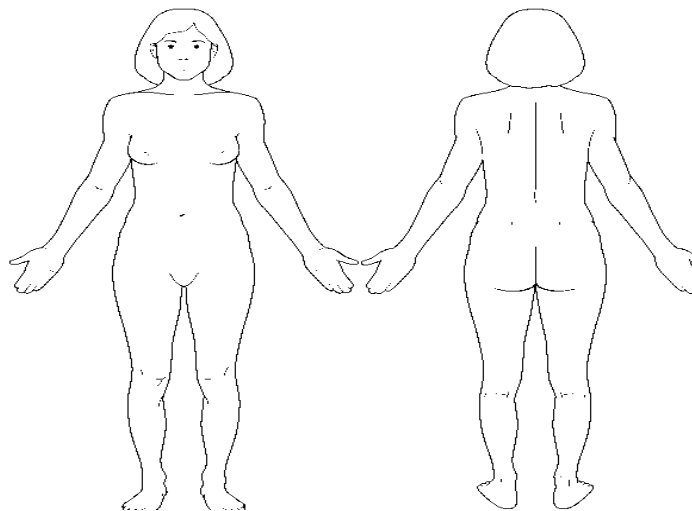
RECORD YOUR DIET FOR 3 DAYS (include beverages):

Breakfast	Lunch	Dinner	Snacks	# of Glasses of Water

Is there anything that you feel is important that has not been covered?

____
____
____
____
____

Please Indicate Areas of Discomfort:



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ACKNOWLEDGEMENT:

It is my choice to receive traditional naturopathic services. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Teresa Myers and Serenity Health & Wellness Center of any changes to my health status. I understand that Serenity and Teresa Myers are not liable for any unforeseen medical issues that I may experience or complications that may arise that could be related to an undiagnosed, pre-existing medical condition prior to or after my treatment. I will disclose any concerns; health related or otherwise as well as discuss any pre-existing conditions to Serenity and Teresa Myers prior to receiving a treatment. I understand that I am responsible for my service charges at the time of service.

I understand that Traditional Naturopathic Doctors do not diagnose illness, disease, physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations.

I acknowledge that these services are not a substitute for medial examination or diagnosis, and that it is recommended I see a primary health care provider for that service.

____ ______________

Signature Date

Cancellation Policy

If you need to cancel or reschedule you appointment, please give us at least 12 hours' notice prior to your service. This is a courtesy to our therapist and will enable us to accommodate other clients. There will be a 50% service fee charged to the client if a cancellation call does not take place on the first occurrence and 100% service fee thereafter. Thank you for your cooperation. We appreciate your business.

»___________________________ (Client Initial)