Naturally Unbridled Wellness Intake Form Today's Date ____/___/____

Name: _____ __ Male __ Female

Birthdate: _____ Age: _____ Email:_____

FULL Address: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Emergency Contact Phone: _____

Referred by: _____

Reason for visit: _____

_____

How long have you had this condition? _____

Is it getting worse? _____ Does it bother your: ___ Sleep ___Work ___Other (what?)

What seemed to be the initial cause? _____

Your Past Medical History

(**Mark C or P** (**C for Current, P for Past)** any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

___AIDS/HIV	___Diabetes (1 or 2)____	___Measles	___Seizures
___Alcoholism	___Emphysema	___Multiple Sclerosis	___Stroke
___Allergies	___Epilepsy	___Mumps	___Surgery (list)
___Appendicitis	___Goiter	___ Pacemaker	_____
___Arteriosclerosis	___Gout	___Pleurisy	_____
___Heart Disease	___Pneumonia	___Thyroid disorder	
___Birth Trauma (Your own)	___ Hepatitis	___Polio	____Tuberculosis
___Cancer	___ Herpes	___Rheumatic Fever	____Typhoid Fever
___Chicken Pox	___ High Blood Pressure	___Scarlet Fever	
___Ulcers	___Venereal Disease (STD)	___Major Trauma (Car, fall, etc. - list)	
___Whooping Cough	___ Root Canal	___ Dental Implants	___ Amalgam fillings
___Other (Specify)		___ Burns	___ Tattoo(s)

Pharmaceuticals taken in last two months:

_____

_____

_____

_____

Vitamins/ Supplements taken in last two months:

_____

_____

_____

_____

ARE YOU CURRENTLY PREGNANT OR NURSING? _____

Other_____

_____

_____

How long do you think it will take to reach your wellness goals?
Do you have: ____< Seizure Disorder ____ <Pacemaker ____ <Lightening Strike ____ <Alcoholism

How willing are you to make lifestyle changes to improve your situation?
Not Willing Slightly Willing Willing Very Willing

Massage, Zone Therapy, CranioSacral, Reiki

REASON FOR YOUR VISIT:
___relaxation ___nurturing ___ athletic training ___medical referral ___ sore muscles ___other*
* _____

MAJOR AREAS OF COMPLAINT, PAIN, TENSION_____

How would you characterize your present state of health? ___excellent ___ good ___fair
Please check all of the following therapies that you have previously experienced:

___ Acupuncture	___ Massage	___ Chiropractic	___ Biofeedback	___ Reiki
___ CranioSacral	___ Zone Therapy	___ Cupping	___ Detox Foot Bath	___ Remedies

Preferences (circle):

Head cradle	Electric massager	Scalp massage	Abdominal massage
Heat packs	Knee support	Facial massage	Music
Table Warmer	Foot Warmer	Cool Room	Warm Room

I understand that Patti Bartsch, Ph.D. and the practitioners at Naturally Unbridled Wellness LLC are not medical professionals; therefore they do not diagnose, treat, cure, or prescribe for any disease or condition. Their comments are not a replacement for qualified medical care. I have stated any medical conditions that apply to me and I take it upon myself to keep the practitioners up to date on health changes

_____ _____
signature date

Checking in on Facebook allows others to know that we are here to help! Thank you!

You may include any other information that you feel may be helpful to us below: