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? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? ____Yes ____No

If yes, for what? _____

Who is your physician? _____ Chiropractor: _____

List any children (and ages) or pets at home:_____

_____

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)

Your Lifestyle - Mark C or P (**C for Current, P for Past)**

___ Alcohol ___Stress ___ Recreational Drugs ___Regular Exercise

___ Tobacco ___ Occupational Hazards or exposure to toxins

Your Diet

Appetite ___Low ___Coffee/Caffeine ___Artificial Sweetener
___ High ___Soft drinks ___ Sugar ___ Salty Food

Thirst for water/ # glasses per day: _____

Average Daily Menu:

Morning:	Snack:	Noon:	Snack:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Evening:	Snack:
_____	_____
_____	_____
_____	_____

Pharmaceuticals taken in last two months:

_____
_____
_____
_____

Vitamins/ Supplements taken in last two months:

_____
_____
_____
_____

General Symptoms - Mark C or P (**C for Current, P for Past)**

___Poor appetite ___Bodily heaviness ___Bleed or bruise easily
___Heavy appetite ___Cold hands or feet ___ Peculiar taste (describe)
___Strongly like cold drinks ___Poor circulation ___Recent weight loss/gain
___Strongly like hot drinks ___Muscle cramps ___Chills ___Grief/Emotions
___Poor sleep ___ Vertigo or dizziness ___Heavy sleep ___Fever
___Night sweats ___Dream- disturbed sleep ___Sweat easily ___Fatigue/Weak

Head, Eyes, Ears, Nose, Throat - Mark C or P (**C for Current, P for Past)**

___Glasses ___Sores on lip or tongue ___Migraines ___TMJ
___Eye strain ___Dry mouth ___Concussions ___Night blindness
___Eye pain ___Excessive saliva ___Swollen glands ___Blurred vision
___Glaucoma ___Cataracts ___Itchy eyes ___ Ringing in ears
___Red eyes ___Poor vision ___Spots in eyes ___Poor hearing
___Earaches ___Enlarged thyroid ___Recurrent sore throat
___Lumps in throat ___Excessive phlegm ___Color of phlegm _____
___Teeth problems ___Nose bleeds ___Grinding teeth ___Contact Lenses
___Facial pain ___Gum problems ___Headaches ___Dentures

other head or neck problems:

Respiratory - Mark C or P (**C for Current, P for Past)**

___Cough Wet or dry?_____ ___Coughing blood ___Pneumonia ___Tight chest
___Shortness of breath ___Asthma/wheezing ___Difficulty breathing when lying down

Color of phlegm_____ Thick or thin? _____

Cardiovascular - Mark C or P (**C for Current, P for Past)**

___High blood pressure ___Chest pain ___Heart condition ___Blood clots
___Low blood pressure ___Difficulty breathing ___Irregular heartbeat ___Phlebitis
___Tachycardia ___Varicose Veins ___Heart palpitations ___Fainting

Gastrointestinal - Mark C or P (**C for Current, P for Past)**

___Nausea ___Intestinal pain or cramping Bowel movements:
___Vomiting ___Itchy anus Frequency_____
___Acid regurgitation ___Burning anus Color_____
___Gas ___Rectal pain Texture_____
___Hiccup ___Hemorrhoid Form_____
___Bloating ___Anal fissures Odor_____
___Bad breath ___Diarrhea ___Constipation
___Laxative Use ___Black stools ___Bloody stools ___Mucus in stools

Musculoskeletal - Mark C or P (**C for Current, P for Past)**

___Neck/Shoulder pain ___Joint pain ___Muscle pain ___Arthritis
___Rib pain ___Limited use ___Limited range of motion
___Upper back pain ___Low back pain other (describe) _____
___Osteoporosis ___Osteopenia ___Acute pain ___Chronic pain
___Bursitis/tendonitis ___Sports Injury ___Sprain/Strain ___Fracture
___Spinal injury or surgery

Skin and Hair - Mark C or P (**C for Current, P for Past)**

___Rashes ___Dandruff ___Psoriasis ___Fungal infection
___Acne ___Hives ___Itching ___Ulcerations
___Hair loss ___Eczema ___Change in hair/skin texture

Neuropsychological - Mark C or P (**C for Current, P for Past)**

___Seizures ___Irritability ____other (specify) _____
___Numbness ___Easily stressed ___ Seeing a therapist/counselor
___Tics ___Abuse survivor ___ Anxiety
___Poor memory ___Considered/attempted suicide ___ Depression ___Vertigo

Genito-Urinary - Mark C or P (**C for Current, P for Past)**

___Pain on urination ___Venereal disease ___Impotence
___Frequent Urination ___Bedwetting ___Premature ejaculation
___Urgent Urination ___Wake to urinate ___Nocturnal emission
___Blood in urine ___Increased libido ___Unable to hold urine
___Decreased libido ___Incomplete urination ___Kidney stone

Gynecology - Mark C or P (**C for Current, P for Past)**

Age menses began_____ ___Vaginal discharge #Live Births_____ ___ Fibroids
Length of cycle (day 1 to day 1) (color) _____ Premature births_____
_____ ___Vaginal sores Age at menopause_____
Duration of flow_____ ___Vaginal odor Date of last PAP
___Irregular periods ___Clots _____
___ Painful periods ___Breast lumps Date last period began
___PMS #Pregnancies_____ _____

ARE YOU CURRENTLY PREGNANT OR NURSING? _____

Other_____

_____

_____

Are you looking for natural symptom support or do you want to get to the root cause of the issue?

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(parent or guardian if under 18) 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:

***Please give to receptionist when completed**