LUCIA HEALTH
WHOLE PERSON CARE

Intake Form

Name _____ **DOB** _____ **M/F**

Address _____

Home phone _____ **Cell phone** _____

Email _____ **Referred by** _____

Occupation _____ **Hobbies** _____

Emergency contact name _____ **Phone** _____

Please list current medications and supplements and its intended use.

_____

_____

Please any allergies and your treatment for them.

_____

_____

Please check all that apply:

General Medical Problems:

____ Abdominal/ Digestive problems
____ Allergies: _____
____ Asthma
____ Bed wetting
____ Breast: _____
____ Breast implants
____ Upper respiratory
____ Lower respiratory: ie. Bronchitis
____ Cancer: _____
____ Cardiovascular: ___
____ Chest pain: _____
____ Colic (baby)
____ Constipation
____ Diabetes: Type ____
____ Diarrhea
____ Dizziness
____Ear or eye problem: _____
____ Edema: _____
____ Fatigue
____Fibromyalgia
____ Fibroids: _____
____ Gall bladder
____ Heating pad/ice pack usage
____ Headaches
____ Heart problems
____ Hernia
____ Incontinence/ bladder
____ Infertility
____ Jaw/TMJ
____ Liver: _____
____ Lung: _____
____ Magnet usage
____ Migraines
____ Numbness
____ Orthodontia
____ Osteoporosis
____ Pain: _____
____ PMS: _____
____ Pregnancy: Weeks _____
____ Prostrate
____ Sinus Problem
____ Sleep/energy
____ Tinnitus
____ Uterine or ovary problem
____ Other: _____

Orthopedic Problems:
Please specify joint replacements, fractures, strains, sprains, dislocations, etc.

____ Arthritis: location _____
____ Foot: _____
____ Ankle: _____
____ Knee: _____
____ Hip: _____
____ Low back: _____
____ Mid back: _____
____ Upper back: _____
____ Neck: _____
____ Head: _____
____ Shoulder: _____
____ Elbow: _____
____Wrist/Hand: _____
____ Orthotics in shoes
____ Scoliosis

Other:
_____

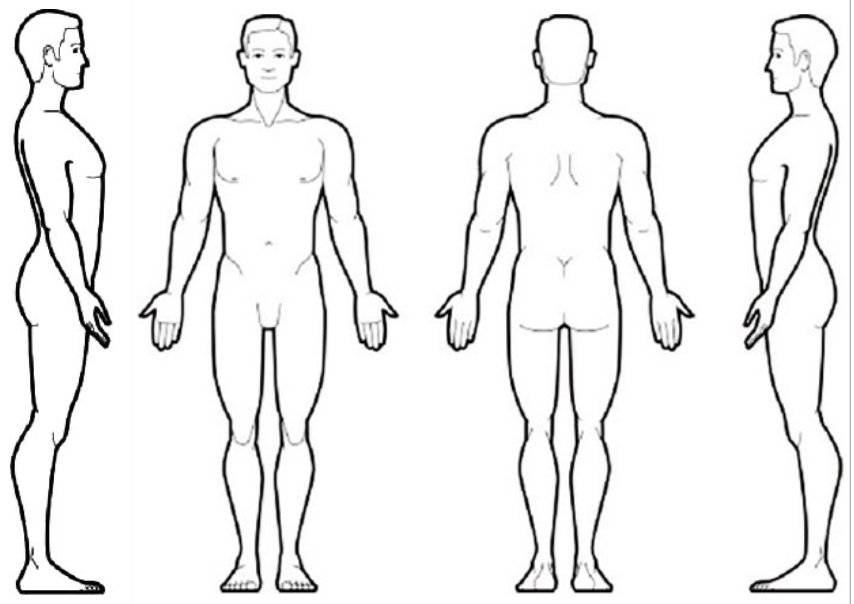
Please describe your condition/s, including dates and length of time experienced. Please list all accidents, injuries, surgeries and falls.

_____

_____

Please list activities compromised by condition/s.

Shade in the site/s of pain on the drawing below, and please describe and rate the pain on a scale of 1-10.



Pain type:
Dull
Achy
Sharp
Shooting
Burning

Pain intensity:
2 – mild pain (annoying)
4 – uncomfortable (troublesome)
6 – distressing (agonizing)
8 – intense (horrible)
10 – excruciating (unbearable)

Previous treatment received (ie. Physical therapy, chiropractic, massage, rest, etc.) and what worked:

_____

_____

_____

Please describe your sleep (ie. Hours, interrupted, inconsistent, wake up at certain time):

_____

Please describe your nutrition (ie. Type of food usually eat, where dine out, skip meals, etc.):

_____

Please describe your bowel habits (ie. Frequency, quality, color, etc.):

_____

The information you provide below will be used to guide sessions accordingly.
Please indicate if you have especially sensitive areas on your body due to past injury, illness, accidents, surgeries, or trauma/abuse. Please also indicate when these areas became sensitive and what you currently do for them.

_____

_____

_____

_____

I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork® and osteopathic techniques are given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my practitioner of any changes in my condition, and will contact my practitioner should I have any concerns.

I understand, as the client or responsible party, that I am fully responsible for full payment. I understand that payment is due at the time of my appointment and that insurance is not accepted. Payment maybe made by check, cash, or credit options. I also understand that if I no show or late-cancel for an appointment, I will be charged $40.

For the treatment of minors, I hereby grant permission for therapy to be performed on this minor.
Notice of Privacy Practices
Any health information or identifying factors you provide will remain confidential and will be stored according to HIPPA compliance practices. You may be contacted to for appointment reminders, treatment alternatives, or other health-related benefits or services that may be of interest to you. Any other use, such as disclosing medical information for specific purposes, will be made only with your written authorization.

Email/Digital Consent
Lucia Health allows clients to communicate via email/other digital methods even though it comes with risks. I have been advised that email/digital communication is not appropriate for urgent health matters or emergencies, shared email/digital accounts or computers can compromise privacy, email/digital methods is not an effective or timely method of communication, and email/digital correspondence may be included in record keeping. Lucia Health will make every reasonable effort to ensure email/digital correspondence is confidential and will only be used for clients over 18 years of age. If you not want to receive appointment reminders, home programs, or newsletters via email/digital methods, please verbally communicate your wishes to Lucia Health.

Signature _____ Date _____