LUCIA HEALTH
WHOLE PERSON CARE

Intake Form

Name _____ **Birth date:** _____ **Gender at birth:** _____

Address _____

Phone: (Home or Cell - please circle one) _____ **Email** _____

Occupation _____ **Hobbies** _____

Emergency contact name _____ **Their Phone/Relationship:** _____

Referred by _____

Please check all that apply:

General Medical Problems:

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

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

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

Have you ever taken antibiotics? Yes No
If yes, when, name of drug, for what purpose? _____

Have you ever taken cortisone or blood pressure medicine? Yes No
If yes, when, name of drug, for what purpose? _____

Have you ever taken birth control/hormone replacement/other hormones? Yes No
If yes, when, name of drug, for what purpose? _____

Did your mother have the same symptoms before you were born? Yes No

Have you been experiencing chronic pain for more than 6 weeks? Yes No What happens when you are stressed? _____

Which of the following best describes you? Please circle below

IBS - C/D	fever
sore throat	high cortisol
appendix	mineral deficient
delayed onset allergies	inability to gain muscle
joint pain	reoccurring injury
food sensitivities	

anaphalaxis	allergies
mucus/running nose	asthma
swelling	acid reflux
antibiotic use	
skin issues	

Please list current medications and supplements and its intended use.

_____

_____

Please list any allergies and treatment for them.

_____

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

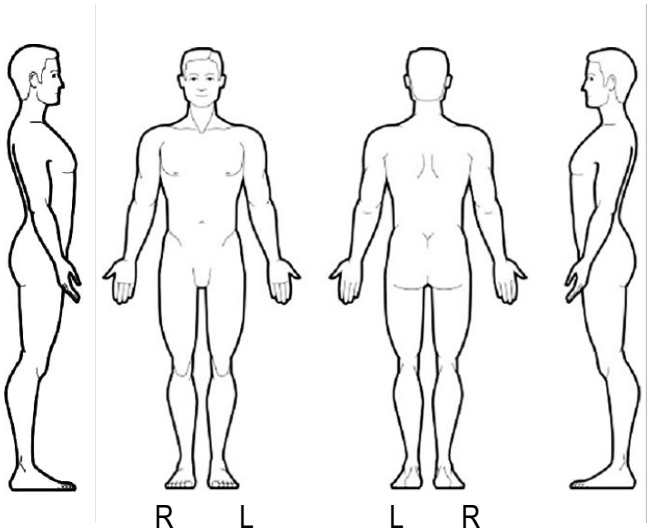
_____

_____

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 in middle of night):

_____

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, diarrhea/constipation, etc.):

_____

***************The information you provide below will be used to guide sessions accordingly. ***********************

Have you received professional massage/bodywork before? Yes No If yes, how often? _____

Do you have difficulty lying on your back, stomach, or sides? Yes No

Do you have allergies/sensitivities to oils, lotions, essential oils, etc.? Yes No If yes, please list: _____

Do you wear contacts (Yes), hearing aid (Yes), dentures (Yes), other devices (ie. insulin pump, defibrillator, medication patches, etc.) (Yes - please list: _____)? No

Please indicate if you have especially sensitive areas on your body for whatever reason or 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. Or conversely, please list any areas that are numb/decreased sensation.

_____

_____

FOR MANUAL LYMPHATIC DRAINAGE THERAPY ONLY

What reason do you seek manual lymphatic drainage? _____ relaxation _____ medical/post surgery _____ GI support _____ cardiovascular support _____ immune system support _____ breast health _____ veins _____ other: _____

Do you HAVE A HISTORY of stroke, blood clots, congestive heart failure, infection, or cancer? Yes No

If yes, please explain:_____

Do you CURRENTLY HAVE ACTIVE infection/fever, blood clots, renal disease, cancer, or untreated congestive heart failure? Yes No

If yes, please explain: _____

Do you CURRENTLY HAVE skin issues - cellulitis, rash, scars, lumps, HSV, etc.? Yes No If yes, please explain: _____

Do you CURRENTLY HAVE lymph issues - node removal/enlargement, swollen extremities, or blood pressure, kidney, or veins issues?

Yes No If yes, please explain: _____

Have you been cleared by your doctor to receive MLD if you have a current medical issue? Yes No Doctor Name: _____

Please list the type of surgery you had done and its details.

Surgery Date	Surgeon	Procedure: Liposuction, Breast, Tummy Tuck, BBL, Gastric Bypass, Lap Band, Face Lift, Joint replacement, hysterectomy, orthopedic, etc.

I have stated, to the best of my knowledge, my known medical conditions. I understand that Bowenwork® , osteopathic techniques, and various massage techniques/bodywork are given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from tissue 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 (name), _____.

Notice of Privacy Practices - Any health information or identifying factors you provide will remain confidential and will be securely stored. You may be contacted 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 _____