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Anna Galati CBP., DMH., DynHC., B.P.H.E

New Patient Intake

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Main Health Goals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications (please list ALL medications you are taking):

 Prescriptions/OTC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Supplements (vitamins/herbs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Average daily water consumption : Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? No \_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ Weekly Average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weekly consumption of beverages? Coffee\_\_\_\_\_\_ Tea\_\_\_\_ Soft Drinks \_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_

Do you smoke? No \_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ Daily Average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

 Seasonal (pollen,hay fever) No \_\_\_\_ Yes \_\_\_\_ Mild \_\_\_\_ Moderate \_\_\_Severe \_\_\_\_

 Other (sensitivies, anaphylaxis, food etc.): No \_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet (low fat, gluten-free etc.) No \_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Specific food cravings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sleep posture: side \_\_\_\_\_\_ back \_\_\_\_\_\_\_\_\_ stomach \_\_\_\_\_\_\_

Number of hours sleep per night: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of sleep (ie. refreshing, unbroken) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep environment (ie.quiet, peaceful, 100% darkness): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did/do you wear braces on your teeth? No \_\_\_\_\_ Yes \_\_\_\_\_ # months/years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did/do you wear a dental appliance? No \_\_\_\_\_ Yes \_\_\_\_\_\_

Did/do you have mercury dental amalgam? No \_\_\_\_\_\_ Yes \_\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery/hospitalizations? No\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Accients/injuries? No \_\_\_\_\_\_ Yes \_\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Change in weight? (greater than 10lbs in the last 6 months) No\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_

Regular exercise program: No \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_

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All Current (C) and Past Conditions (P)

|  |  |  |
| --- | --- | --- |
| **MUSCLES/JOINTS/NERVES**C P **Head and Neck**\_\_ \_\_ headaches/migraines\_\_ \_\_ neck pain/whiplash\_\_ \_\_ tingling/numbness\_\_ \_\_ tooth/jaw/ear pain/TMJ\_\_ \_\_ vision condition (s)\_\_ \_\_ hearing condition/dizziness\_\_ \_\_ head trauma/concussion\_\_ \_\_ loss of coordination**Trunk**\_\_ \_\_ back pain/injury/scoliosis\_\_ \_\_ degenerative/herniated disc\_\_ \_\_ hip pain/sciatica**Arms / Hands / Legs / Feet**\_\_ \_\_ pain/tingling\_\_ \_\_ weakness/numbness\_\_ \_\_ fractures/strains/sprains\_\_ \_\_ tendonitis/fibrositis/bursitis\_\_ \_\_ osteo/rheumatoid arthritis\_\_ \_\_ muscle/nerve disease**Skin**\_\_ \_\_ lack of sensation/numbness\_\_ \_\_ irriated condition/frostbite\_\_ \_\_eczema/psoriasis/skin infection | **HEART/CIRCULATION**C P\_\_ \_\_ high/low blood pressure\_\_ \_\_ chest pain/angina\_\_ \_\_ heart attack/stroke\_\_ \_\_ heart disease\_\_ \_\_ pacemaker\_\_ \_\_ bruise easy\_\_ \_\_ arrhythmia\_\_ \_\_ phlebitis/thrombosis**LUNGS RESPIRATION**\_\_ \_\_ shortness of breath\_\_ \_\_ chronic cough\_\_ \_\_ asthma bronchitis\_\_ \_\_ emphysema**DIGESTION**\_\_ \_\_ IBS/Crohn’s/colitis\_\_ \_\_ Celiac disease\_\_ \_\_ constipation/diarrhea (chronic)\_\_ \_\_ nausea/bloating/gas (chronic)\_\_ \_\_ ulcer/hernia**UROGENITAL** \_\_ \_\_ liver/gall bladder \_\_ \_\_ urinary infection/disease\_\_ \_\_ kidney infection/disease | **GENERAL/SYSTEMIC**C P\_\_ \_\_ anxiety/stress\_\_ \_\_fatigue/insomnia\_\_ \_\_eating disorder\_\_ \_\_drug/alcohol issues\_\_ \_\_ fibromyalgia/chronic fatigue\_\_ \_\_ osteoarthritis/osteoporosis\_\_ \_\_inflammatory arthritis\_\_ \_\_diabetes\_\_ \_\_ undiagnosed lump\_\_ \_\_cancer\_\_ \_\_epilepsy\_\_ \_\_TB/hepatitis/HIV\_\_ \_\_internal pins/plates/wires\_\_ \_\_artificial joints**WOMEN**\_\_ \_\_ menstrual changes/problems\_\_ \_\_endometriosis\_\_ \_\_PMS/menopausal complications\_\_ \_\_other gynecological conditions\_\_ \_\_pregnant –due date? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MEN**\_\_ \_\_ prostrate problem\_\_ \_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Check box if applicable; CIRCLE specific conditions

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**Statement of Acknowledgement**

Each patient seeking care from Soul Remedy Holistic Clinic should understand that the Bowen Practioner is certified and specialized in Bowen Therapy and specialized in Heilkunst Treatment and is not a Medical Doctor. If standard medical diagnosis or treatment is required, it must be obtained from a licensed Medical Doctor.

**Patient Consent Form**

Privacy of your personal information is an important part of providing you with quality care. This document is confidential information and will not be released to any persons without your consent.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

   

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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