Holistic Homeostasis
HEALTH • HEALING • HARMONY

ADULT INTAKE FORM

Full Name: ______________________________ Pronouns: __________

Postal Address: ______________________________

E-Mail Address: ______________________________ Primary Phone #: __________

Age: __________ Date of Birth: ______________________________

Marital Status: Married / Common-Law Partnership / Single / Divorced / Widowed / Other: ________

Living Situation (circle): With Partner / Family / Roommate / Alone / Other – specify: __________

Number and Age of Children (if applicable): ______________________________

Occupation & Place of Work : ______________________________

Work: Full-Time / Part-Time / Occasional Work Hours: ______________________________

Name of Family Doctor/Nurse Practitioner: ______________________________

Specialists Doctor(s):______________________________

Current Condition: please explain why you are here, describe any injury/pain, dysfunction or main symptoms, and how and when it started:

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List any therapy you have had/are currently undergoing, or any health professionals/practitioners you have consulted for this condition:

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Health Conditions, Indicate ("X") if past or present:

Past	Present	System	Please Specify
		Musculoskeletal (injuries, sprains, tears, back pain, etc.)	
		Nervous (headaches, anxiety, burnout, multiple sclerosis, Parkinson's, etc.)	
		Respiratory (asthma, COPD, sleep apnea, frequent upper respiratory tract infections, etc.)	
		Endocrine (diabetes, thyroïde problems, etc.)	
		Immune (autoimmune diseases, cancer, allergies, etc.)	
		Cardiovascular/Circulatory (blood pressure, heart attack, stroke, arrythmias, etc.)	
		Urinary (urinary tract infections, incontinence, kidney stones, etc.)	
		Integumentary System (acne, skin cancer, rashes and skin conditions, etc.)	
		Reproductive (endometriosis, PCOS, infertility, STIs, etc.)	
		Digestive (GERD, IBS, IBD, constipation/diarrhea, ulcers, nausea, vomiting, etc.)	

Additional information:

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List any significant family history:

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List any/all medications you take, what it's for and how long have you been taking it:

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List any/all supplements/natural remedies you take, what it's for and how long have you been taking it:

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List any recreational drugs you use and frequency:

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List any surgeries you have had:

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List any significant past injuries, accidents, major life events, or difficult experiences/trauma (physical/mental/emotional) you have experienced:

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Do you have any problems with the following? Please explain:

- Digestive Problem: ____
- Sleep: ____
- Mental/Emotional: ____
- Breathing: ____
- Memory: ____
- Fatigue/Energy Levels: ____

Do you have any other health concerns:

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What is your primary source of stress:

How do you cope with stress:

List the type of physical activity you do and the frequency:

Briefly describe your dietary habits (following any specific diet, food restrictions and/or intolerances, etc.):

List activities/hobbies you enjoy and participate in:

Have you ever had craniosacral therapy? Yes / No If so, how was your experience?

What are your expectations from these treatments/therapy?

List 3 goals or objectives (in order of importance) you would like to achieve from our work together:

1. ______________________________

2. ______________________________

3. ______________________________

Is there anything else that you think would be helpful for me to know?

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How did you find out about this therapy/clinic?

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