

Wellness Intake Form



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Date _____

Name _____

Cell Phone _____

Address _____

Work Phone _____

City/State/Zip _____

Home Phone _____

Occupation _____

Email _____

Marital Status Married Single Widow Divorced Separated

Emergency Contact _____

Number of children _____

Emergency Phone _____

Birth Date: Month _____ Day _____

Referred by _____

Height _____ Weight _____ Age _____

Health concerns for which you came today _____

When did the condition develop & describe symptoms & diagnosis given _____

What makes this condition worse? _____

List treatment currently prescribed for this condition _____

Describe results of previous treatment(s): (chiropractic, massage, PT, etc) _____

Are you presently under a physician's care: (Other than annual physicals) Yes No

If so, please explain _____

List surgeries, accidents & illnesses (dates) _____

List medications & reason for their use _____

List over-the-counter medications & supplements _____

Wellness Intake Form

Do you regularly drink caffeine beverages none coffee tea coke other _____

Do you smoke? Yes No If so, how many packs a day? _____

Do you drink alcoholic beverages? Yes No If so, how much? _____

Are you pregnant? Yes No If so, what is the expected delivery date? _____

Are you participating in a regular fitness program? Yes No

If so please describe _____

How many hours a night do you sleep? _____ Is your sleep restful? Yes No

If not, at what times or how often do you wake _____

Do you have trouble falling asleep staying asleep neither

Do you have any medical condition and/or physical limitation that your practitioner needs to be aware of before you receive treatment? Yes No

If so, please explain _____

Please check all the areas of pain below

Upper Body

Back

Arms

Legs

Head	Upper	Shoulder	Left	Right	Hip	Left	Right
Neck	Middle	Elbow	Left	Right	Knee	Left	Right
Chest	Lower	Wrist	Left	Right	Ankle	Left	Right
Abdomen	Sacrum	Hand	Left	Right	Foot	Left	Right
	Sacroiliac Joint						

Other _____

Please check any of the following feelings you have experienced in the last few months:

Abused	Rejected	Overwhelmed	Unable to grieve	Fearful	Intolerant	Outraged
Criticized	Despair	Muddled	Apprehensive	Impatient	Uncertainty	Nervous
Overworked	Helpless	Persecuted	Agitated	Intimidated	Aggravated	Worry
Paralyzed	Hopeless	Guilty	Uneasy	Restless	Annoyed	Anxiety
Depressed	Paranoid	Easily irritated	Distress	Panic	Angry	

Wellness Intake Form

Please check any of the symptoms you experience **S**ometimes **O**ften **P**ast (Leave BLANK if NEVER)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose stools/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching, Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of distension after meals:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive in work / relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to catch colds easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intolerant to weather changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Bruised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult to stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty digesting oily foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia, difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light colored stools
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive dreaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft or brittle nails
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily angered / irritated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making plans or decisions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to faint easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms / twitching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe menstrual pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe irritability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand/feet cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ (temporal-mandibular joint)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

Consent and Disclosure Agreement

I, _____ (Print Name; if minor, include name of a parent) understand my sessions include a mind-body approach intended to enhance relaxation and increase communication between the mind and the body.

Please read and initial the following statements:

Any information provided by the Practitioner is educational and to be used at my discretion. I agree.

I know that the Practitioners at The Retreat are not medically licensed doctors and will not diagnose, treat, or prescribe for illness, injury, disease, or other pathological condition, or perform any act which constitutes the practice of medicine. I understand that sessions are not substitutes for medical treatment or medications. I agree.

I understand that I may experience so-called "detoxification symptoms" or releases during the 24-48 period following the session and that these may be uncomfortable if my current level of stress is heightened. I agree.

I understand participation in a session is voluntary and at any time I may choose to end my participation. In addition, the session may entail light tapping and contact of energy points of the body. The Practitioner will inform me where tapping and/or contact (by the practitioner and/or myself) will occur, thus allowing for ongoing consent. I agree.

It is my responsibility to inform my Practitioner of any medical conditions or medications I am currently taking. I understand that although I may seek information and counseling from my practitioner, my health and well-being or that of my child, is my own responsibility. It is my responsibility to consult my primary care provider or to seek out other medical help when necessary. I agree.

All information exchanged will be considered confidential and will not be released without written consent, or as required by law. I agree.

I understand that by providing this informed consent I am assuming full responsibility for my Mind Body Energy or Resistance Flexibility Session(s) and I hold harmless both the Practitioner and location where the session is done including Therapy In Motion, Norman, OK. I agree.

Session Charges:		Springman
Initial session:	75 min	\$175
Follow-up sessions:	60 min	\$150
Extra time	per 15 min	\$25

Remote sessions are charged the same as office visits. I agree.

Payment is expected at the time of services. I agree.

I consent to receive and pay for any and all remote sessions per the standard rate. I agree.

I understand a 24-hour cancellation notice is expected and missed appointments will be charged at a rate of \$50. I agree.

If I have any questions or concerns, I will address these promptly with the practitioner. I authorize the practitioner to provide me (or the child/dependent listed above) with Session(s). ***If submitting this form by email and signature is not typed or signed, it is understood that by emailing the form that I agree to the terms listed above.***

Sign or Type Name _____ Date _____

Practitioner _____ Date Reviewed _____

Helpful Suggestions for an optimal Mind Body Session

*Please bring the completed intake form to your first appointment.

*Read all materials carefully and make note of any questions you wish to discuss.

*During your session, you will be lying face up on a massage table. Please wear natural fiber clothing, like cotton. It is especially important that you avoid wearing any nylon, spandex, or metal, including under wire bras if possible. Jewelry, glasses and shoes can be removed prior to your session.

*Please arrive early in order to enjoy the full time of your appointment. Late arrivals may result in your session being limited due to time constraints.

***Please give at least 24 hours notice when canceling an appointment.