JOY BLACK

MEDICAL QIGONG & MIND-BODY PRACTICE

Confidential Client History/Intake Form

Name_____Date_____ Date of birth____/____/____

Address_____

City_____State_____Zip_____

Phone (home)_____Cell_____Other_____

E-mail_____ Add to Mail List? ____Yes ____No

Referred by_____

Type of session you seek:

Medical Qigong*_____ Energy Work**_____ Guided Meditation_____ Other_____

Surgical Support_____ Pediatric_____ * includes Chi Nei Tsang ** blends Healing Touch & Reiki

Main reason for seeking session:

Living situation (spouse/partner, alone, pets, social support):

Health professionals seen (mark all that apply):

Naturopathic Physician Date:	Western Physician Date:	Nurse Practitioner Date:	Physical Therapist Date:	Specialist Date:
Chiropractor Date:	Osteopath Date:	Nutritionist Date:	Herbalist Date:	Homeopath Date:
Acupuncturist Date:	Massage Therapist Date:	Other_____ Date:		

Additional comments:

Nutrition (describe):

Elimination (mark all that apply):

Regular Constipation Diarrhea It often varies

Water intake:

Number of 8 oz. glasses per day_____

Sleep patterns (mark all that apply):

Insomnia Use sleep aids Oversleep Other_____

Do you use any of the below? If so, what type and how often?

Alcohol_____
Recreational drugs_____
Tobacco_____
Caffeine_____

Personal stresses – use a scale from 0 (no stress) to 10 (extreme stress) for the following:

Health _____ Work _____

Relationships _____ Finances _____

Loss _____ Other _____

Relaxation / Self-Care (mark all that apply):

Exercise/Sports Hobbies Friends/Family Support Groups Other_____

Religious / Spiritual Practices / Belief System:

Do you have any type of meditation experience? Yes_____ No_____ Describe:

What do you believe is the reason for your current health issues?

Medications / Supplements (mark all that apply):

Over-the-counter medication Vitamins
Prescription medication Supplements
Homeopathic remedies Herbal remedies

Have you had any surgeries? Yes_____ No_____ If so, please list them with the year:

Health history and current symptoms (mark all that apply):

Chronic Fatigue	Fibromyalgia	Lyme	Heart
Lung	Digestive Issues	Thyroid/Hormonal	Bronchitis
Liver	Asthma	Stroke	Circulation
Stomach	Gallbladder	High Blood Pressure	Reproductive Organs
Urinary Tract	Clot	Seizures	Sexual Assault/Abuse
Colon	Eating Disorder	Kidneys	Cancer
Diabetes	Vision	Weight Concerns	Hearing
Depression	Headaches	Mental/Emotional	Allergies
Serious Accident/Trauma	Alcohol Concerns	Drug Concerns	Adrenal Fatigue

Other_____

Is there anything else you would like to tell me?

CLINICIAN NOTES: