

# The Center for Health & Healing

## Mind-Body Skills Group Intake Form

Date: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN

Address: \_\_\_\_\_  
CITY STATE ZIP

Sex:  M  F  Single  Married  Partnered  Divorced  Widowed  Separated

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_

Spouse/Partner's Name: \_\_\_\_\_ # of Children: Boys \_\_\_\_\_ Girls \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_  
NAME OCCUPATION/RELATION

In case of emergency, whom should we contact? \_\_\_\_\_  
NAME RELATION PHONE

Are you currently under medical treatment?  Yes  No

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you see any other practitioners in the integrative area?  Yes  No If yes, which area(s)?

Acupuncture  Chiropractic  Naturopathy  Massage  Healing Touch  
 Homeopathy  Chinese Medicine  Nutrition  Reiki  Guided Imagery  
 Hypnotherapy  Biofeedback  Hydrotherapy  Aromatherapy  Ayurveda  
 Chelation  Oxygen Therapy  Prolotherapy  Other Energy Work \_\_\_\_\_  
 Other Bodywork \_\_\_\_\_  Other Practitioners \_\_\_\_\_

Have you ever had any serious illnesses or operations?  Yes  No

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any medications?  Yes  No (Continue list on back of sheet if needed.)

Name of Medication	How much do you take?	How did you come to take this?

Are you currently taking any nutritional supplements?  Yes  No (Continue list on back of sheet if needed.)

Name of Supplement	How much do you take?	How did you come to take this?

**Family History:**

	Name	Health	Age	Major Illnesses	Died	Cause of Death
<b>Father</b>		Good/Poor				
<b>Mother</b>		Good/Poor				
<b>Brother(s)</b>	1.	Good/Poor				
	2.	Good/Poor				
	3.	Good/Poor				
<b>Sister(s)</b>	1.	Good/Poor				
	2.	Good/Poor				
	3.	Good/Poor				

Do you smoke?  Yes  No      How many packs per day? \_\_\_\_\_  
 Do you drink coffee?  Yes  No      How many cups per day? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No      How many drinks per day? \_\_\_\_\_  
 Do you drink soda?  Yes  No      How many drinks per day? \_\_\_\_\_  
 Do you use other drugs?  Yes  No  
 Do you eat regular meals?  Yes  No      How many meals per day? \_\_\_\_\_      Snacks? \_\_\_\_\_  
 Do you sleep regularly?  Yes  No      How many hours per night? \_\_\_\_\_  
 Do you exercise?  Yes  No      What type(s)? \_\_\_\_\_      How often? \_\_\_\_\_

Are you overly stressed in your current work situation?  Yes  No  
 Are you overly stressed in your current home/family situation?  Yes  No  
 If you answered yes, to either of the above questions, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you feel supported in your current work environment?  Yes  No  
 Do you feel supported in your current home/family situation?  Yes  No

Do you have a support system/network?  Yes  No      Please check all that apply:  
 Family       Friends       Spouse/Partner       Community Groups       Physician(s)/Nurse(s)  
 Church/Religious Organization       Other healthcare professionals \_\_\_\_\_  
 American Cancer Association       Other \_\_\_\_\_

What feeds/sustains your life? \_\_\_\_\_  
 \_\_\_\_\_

What drains your life? \_\_\_\_\_  
 \_\_\_\_\_

What gives you a sense of hope? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had a profound spiritual experience?  Yes  No  
 Do you have concerns for any other individuals at this time?  Yes  No  
 What is your greatest concern at this time? \_\_\_\_\_  
 \_\_\_\_\_

What do you see as your greatest hurdle at this time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_