Healing Tree Wellness Center

201 East Main Street, Suite 14 · Floyd, VA 24091 · (540)745-3030 · www.healingtreehealth.com

Office Use Only
- ☐ SOC
- ☐ Email
- ☐ Insightly

Client Intake Form

Today's Date: ___________________

Client Information

Name:

Home Address:

City: State: Zip:

Date of Birth: Age: Cell phone:

Home phone: Email:

Race: Occupation: Marital Status:

Gender:

How did you hear about us, we would love to know who sent you?

I. Health Goals

What brings you to the Healing Tree today, please be specific?

What are your general/long term health goals? What do you hope to accomplish? Achieve? Please describe in detail.

II. Lifestyle

Y	N		
		Do you exercise regularly?	Type:
		Smoking	Amount/Day:
		Alcohol	Drinks/Week:
		Coffee/Caffeine Drinks	Cups/Day:
		Food Cravings	
		Pregnant?	If yes, how far along?

***For Hair Analysis clients – we will be making you a liquid remedy which you will take 5 drops under the tongue 3 times a day. We can make the remedy in just distilled water and it will need to be refrigerated, or we can add a very small amount of alcohol to help preserve the remedy and it will not need to be refrigerated. Would you prefer your remedy made with or with alcohol? No Alcohol ___ Yes Add Alcohol ___**

III. Health Information:

Check if you or your parents have ever been diagnosed with or had problems with any of the following conditions.
[S = Self M = Mother F = Father]

S	M	F		S	M	F		S	M	F	
			Aids/HIV				Fibromyalgia				PMS
			Allergies				Gall Bladder Problems				Parasites
			Anemia				Glaucoma				Pneumonia
			Appendicitis				Goiter				Polio
			Arthritis				Gout				Prostate Problems
			Asthma/Hay Fever				Headaches				Reproductive Problems
			Athlete's Foot				Heart Disease/ Cardiovascular Issues				Rheumatoid Arthritis
			Bleeding Disorders				Hemorrhoids				Scoliosis
			Blood Pressure Problems				Herpes				Sinus Problems
			Breast Lump/Pain				Hepatitis				Skin
			Bronchitis				Hypoglycemia				Spine/Back Problems
			Bursitis				Kidney Disease/Infection				Sleep Disorder
			Cancer				Kidney/Bladder Stones				Thyroid Problems
			Cataracts				Liver				Tuberculosis
			Chicken Pox				Lung				Tumor/Growth
			Colitis				Migraine Headaches				Varicose Veins
			Constipation				Multiple Sclerosis				Vision
			Dental				Mumps				Weight
			Diabetes				Nerves				
			Digestive Problems				Osteoporosis				
			Edema								
			Ears (Ringing, Hearing)								

Other:

List any conditions you are presently under a physician's care for:

List any medications you are currently taking:

Are you allergic to any food or medication?

How would you describe your sleep patterns? (Please circle all that apply.)

a. Fall asleep easily
b. Have problems falling asleep
c. Wake up at certain/same time at night. What time?
d. Other (please describe):

How would you describe your energy levels?

a. Steady throughout the day
b. Trouble getting up in the morning, then I'm okay
c. Hit a wall at a certain time of day. What time?
d. Always tired?
e. Other (please describe):

Where do you hold your tension?

a. Head
b. Neck
c. Shoulders
d. Back
e. Other (upset stomach, clenching teeth or fists):

Are there areas of your life that are particularly stressful? (ex. Job, family, posture, habits, diet, etc.) Please explain.

What posture do you assume most of the day?

Please list any surgeries, fractures or recent injuries you've had.

Surgery/Fracture/Injury	Date

Do you wear contact lenses?

What are your hobbies, interests or activities are you involved in?

What type of weather do you prefer?

Describe your diet by listing foods you most often eat for:

Breakfast	Lunch	Dinner	Snack

IV. Client Statement

1. I understand that I am here to learn about better health practices, bodywork including shiatsu and massage, and nutrition and that I will be offered information about nutrition (including food supplements and herbs), exercise, and other lifestyle interventions as a guide to general good health.
2. I fully understand that the states of Virginia, Pennsylvania or Maryland have not adopted educational or training standards for the practice of naturopathy or shiatsu, and that those who counsel me are not medical doctors or practitioners. As such, I am not here for medical diagnostic purposes or treatment procedures.
3. I am not, on this visit or any subsequent visit, an agent for any federal, state or local agency, nor am I on a mission of entrapment or legal investigation.
4. The services performed by Ivan C. Anderson, Lynise V. Anderson, ND or others at this facility do not involve the diagnosis, treatment or prescribing of remedies for diseases, but are at all times restricted to consultation on the subject of wellness and are intended for the maintenance of the best possible state of health.
5. Information collected may be used to generate statistics to enable us to develop programs to better serve our clients. Your information will not be shared with anyone outside of this facility without your prior consent.
6. Our policy requires that payment is due at the time services are rendered. Payment can be made in the form of cash, personal check (with proper ID), credit card, money order or certified funds. The client will be responsible for any charges incurred in collecting delinquent balances. There is a $25 fee for checks written against insufficient funds.

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Client Signature Date