Meaningful Body

The first somatic therapy clinic in Atlantic Canada

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ADULT INTAKE FORM

GENERAL INFORMATION

Full name: _____ Name called: _____

Date of birth: _____ Age now: _____ Gender: _____

Marital status: Married ____ Common-law ____ Single ____

Occupation: _____ Employer: _____

Address: _____ Town/City: _____

Province: _____ Postal code: _____ Email: _____

Home phone: _____ Cell phone: _____ Work phone: _____

How did you hear about us? _____

If you were referred by another health care provider, please fill in the following fields.

Referred by: _____ Profession: _____

Phone: _____ Reason for referral: _____

HEALTH HISTORY

Please check the conditions that apply to you or that run in your family:

	Yes	No	Details
Arthritis	□	□	_____
Rheumatoid arthritis	□	□	_____
Osteoporosis	□	□	_____
Weight loss/gain	□	□	_____
Cancer	□	□	_____
Diabetes, Type I	□	□	_____
Diabetes, Type II	□	□	_____
Drug sensitivity	□	□	_____
Elevated cholesterol	□	□	_____
Heart problems/disease	□	□	_____
High blood pressure	□	□	_____
Thyroid	□	□	_____
Persistent headaches (including migraines)	□	□	_____
Skin diseases (acne, etc.)	□	□	_____
Gastrointestinal	□	□	_____
Urogenital (bladder, etc.)	□	□	_____
Neurological (MS, seizures, etc.)	□	□	_____
Psychiatric (depression, etc.)	□	□	_____
Respiratory (asthma, bronchitis, emphysema)	□	□	_____
Kidney disease	□	□	_____
Lupus	□	□	_____

Other _____

_____

Are you currently under a physician's care? Yes ___ No ___

If yes, please provide Dr.'s name: _____

Are you taking any medications regularly? Yes ___ No ___ If yes, what medications:

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Allergies: _____

_____

List any major illness you have had:	Age	Mild/moderate	Severe
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any surgeries you have had:	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any chronic problems? Yes ___ No ___

If yes, please list: _____

_____

Do you use a mobility aid? Yes ___ No ___

If yes, what? Walker ___ Wheelchair ___ Other _____

How would you assess your current diet? Circle one: Excellent Good Fair Poor

Explain: _____

_____

Have you had an acquired brain injury/or concussion? Yes ___ No ___

If yes, please complete the **Brain Injury** Section. If no, skip to the **Present Situation** Section.

BRAIN INJURY/CONCUSSION

Date of accident/trauma: _____

Describe the accident/trauma: _____

_____

_____

_____

What part of your head was affected?

_____ Forehead _____ Right side _____ Top of head

_____ Back of head _____ Left side _____ Face

Difficulties following accident/trauma

Work-related: _____

_____

_____

Social: _____

_____

_____

Hobbies/Leisure: _____

_____

_____

Other: _____

_____

_____

Subsequent symptoms

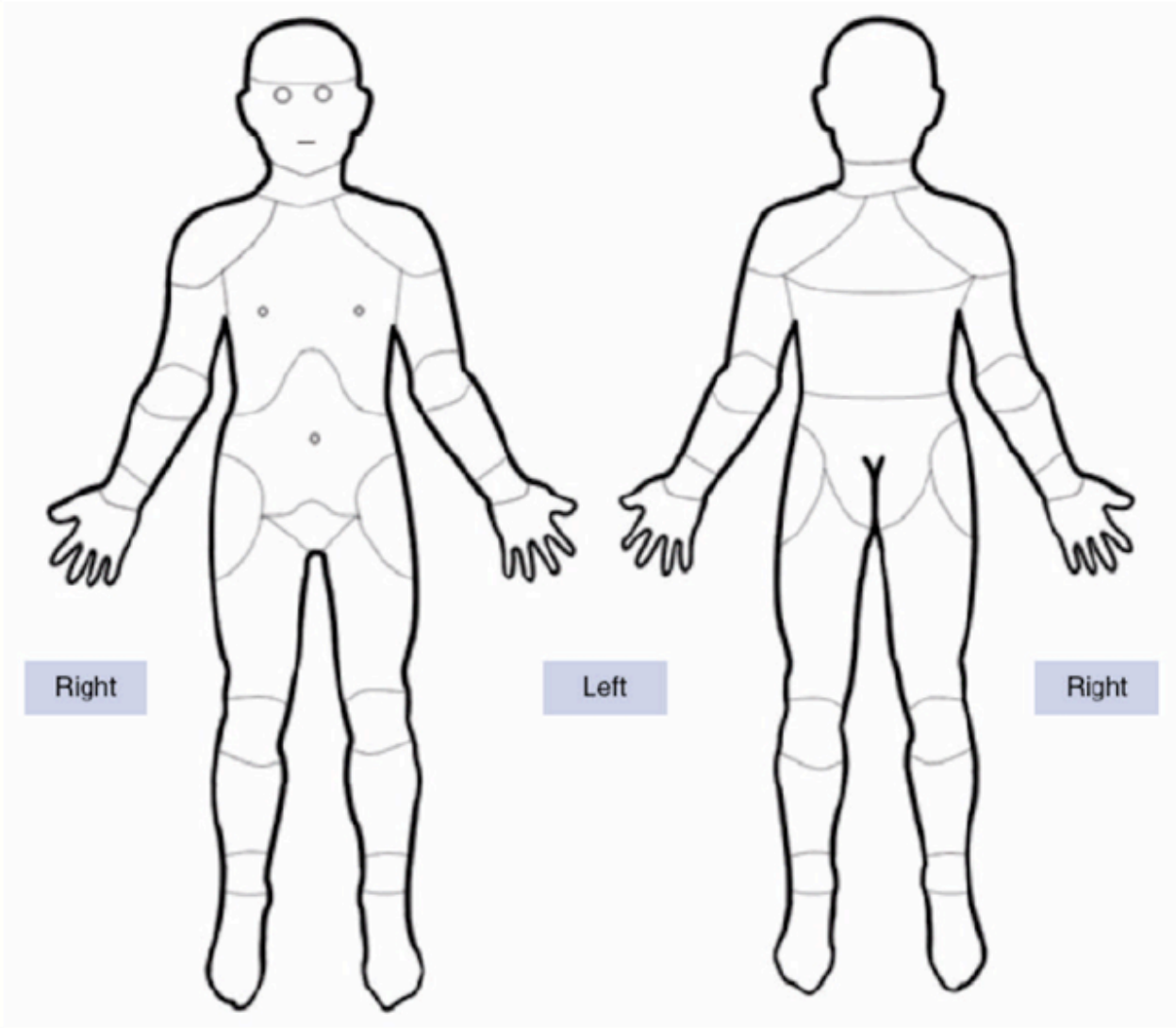
Please consider each symptom and place an "X" in the column that applies.

Symptom	Had before accident, and it has worsened	New symptom since accident		
		Mild	Moderate	Severe
Frequent headaches				
Abnormal general fatigue				
Fatigue associated with mental activities				
Decreased attention span				
Reduced concentration ability				
Comprehension problems				
Memory problems				
Dizziness				
Balance problems				
Poor coordination				
Clumsiness				
Poor posture				
Poor eye-hand coordination				
Poor handwriting				
Disorientation				
Bothered by movement around you				
Bothered by being touched				
Noise sensitivity				
Light sensitivity				

PRESENT SITUATION

Pain location and intensity

Please indicate the usual intensity of pain you have experienced over the past week in each of the body areas shown below, choosing the number that best describes it: 1 — mild; 2 — moderate (discomforting); 3 — severe (distressing); 4 — horrible. Put numbers within corresponding body areas.



Are you currently experiencing any physical problems aside from pain?

	Yes	No
Muscle stiffness	□	□
Muscle weakness	□	□
Unsteadiness	□	□
Fatigue	□	□

Other _____

Pain interference

Please select the **one number** that best describes how, during the past week, pain has interfered with the following aspects of your life:

	Not at all	A little bit	Somewhat	Quite a bit	Very much
General activity	0	1	2	3	4
Mood	0	1	2	3	4
Mobility (ability to get around)	0	1	2	3	4
Normal work (including both work outside the home and housework)	0	1	2	3	4
Relations with other people	0	1	2	3	4
Sleep	0	1	2	3	4
Enjoyment of life	0	1	2	3	4
Self-care	0	1	2	3	4
Recreational activities	0	1	2	3	4
Social activities	0	1	2	3	4
Communication with others	0	1	2	3	4
Learning new information and skills	0	1	2	3	4

Emotional challenges

Are you often bothered by any of the following? Check all that apply.

	Yes	No
Irritability and anger outbursts	□	□
Worry and anxiety	□	□
Fear and panic attacks	□	□
Insomnia, nightmares	□	□
Little interest or pleasure in doing things	□	□
Hopelessness	□	□
Low self-esteem	□	□
Loneliness, not belonging, isolation	□	□

Cognitive problems

Are you often bothered by any of the following? Check all that apply.

	Yes	No
Poor concentration	□	□
Slow thinking	□	□
Losing your train of thought	□	□
Forgetfulness	□	□
Difficulty finding words	□	□
Difficulty paying attention and focusing (for example, when reading or listening to others)	□	□

OTHER HEALTH CARE PRACTITIONERS OR SERVICES THAT YOU SEE/USE

Name Profession

_____

_____

_____

_____

_____

Signature: _____ Date: _____