Client Intake

Date: ______________________________
Name: ______________________________
Date of Birth: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Text confirmation OK? ______________________________
Address: ______________________________
____

Gender: ______________________________
Marital Status: ______________________________
Occupation: ______________________________

Height ______________________________
Weight ______________________________
How did you hear about Wolf Moon? ______________________________
____

What is the primary goal that you would like us to help you with?
____
____
____

How long ago did this issue begin?
____
____

What are the secondary issues (if any) you would like us to help you with?
____
____
____
____

What kinds of treatments have you tried? ______________________________
____
Have they helped your condition? ______________________________
Are you currently receiving treatment for this condition? If so explain ______________________________
____

Current or past illnesses: ______________________________
____
Surgeries: ______________________________
____
Significant Trauma (accidents, falls etc) ______________________________
____
Do you have or have you had any infectious diseases? ______________________________
____

Do you have any allergies? ______________________________
____
Is there any other information that would be important to know for your treatment? ______________________________
____

Client Intake

Medications	Reason for Taking	Amount/Dose	Date Started

Family Medical History

Are you adopted? Yes No

Early Life

Personal Birth Story: (prolonged labor, forceps, caesarean, etc.) ______________________

____

Childhood Health (any severe or recurrent illness, surgeries, traumas etc): ______________

____

____

Location of Upbringing: ____

	Age	Health issues	Age of/Cause of Death
Mother			
Father			
Brother/Sister			
Brother/Sister			

Client Intake

GENERAL

Poor Appetite	Fever(s)	Change in Appetite	Tremors
Cravings	Emotional Changes	Localized Weakness	Insomnia
Strong Thirst	Paralysis	Sudden Energy Drop	Nervousness
Bleeding	Weight Gain	Weight Loss	Sweats Easily
Fatigue	Night Sweats	Hearing Loss	Forgetfulness

SKIN AND HAIR

Rashes	Hair Loss	Change in Hair Texture	Eczema
Hives	Skin Ulcers	Recent Moles	Change in Skin Texture
Acne	Itching	Dandruff	Psoriasis
Skin Eruptions	Clammy Skin	Dryness	Bruises Easily
Boils	Sensitive Skin	Other:	

HEAD, EYES, EARS, NOSE AND THROAT

Sore Throat	Eyestrain	Grinding Teeth	Cataracts
Blurred Vision	Ringing in Ears	Gum Problems	Sores in mouth or Tongue
Floaters in Eyes	Concussions	Jaw Click/TMJ	Ear Pain
Sinus Problems	Night Blindness	Migraines	Facial Pain
Toothache	Nose Bleeds	Color Blindness	Glaucoma

Client Intake

Current Quality of Life: ____________________

Current Emotional Health: ____________________

Stress Level of Occupation: ____________________

Have you had any unusual stresses lately? If so, explain ____________________

____

Your favorite time of year? __________ Least Favorite? __________

Hobbies and recreational habits: ____________________

Do you exercise regularly? __________ Describe: __________

____

Do you find that you sigh frequently? ____________________

Have you traveled abroad in the past year? ____________________
Where? ____________________

Personal Medical History

Please circle all that apply

Cancel	**Asthma**	**Heart Disease**	**Stroke**
Hepatitis	**Herpes**	**Mental Illness**	**Seizures**
Weight Problems	**Rheumatic Fever**	**Addictive Disorders**	**High Blood Pressure**
Mood Disorder	**Diabetes**	**Thyroid Disease**	**Venereal Disease**

Other:

RESPIRATORY

Chronic Cough	Bronchitis	Easily Winded	Coughing Blood
Asthma	Phlegm	Frequent Colds	Wheezing
Painful Breathing	Sighing	Shortness of Breath	
Other:			

CARDIOVASCULAR

Blood Clots	Fainting	Low Blood Pressure	Chest Pain
Swollen Hands	Swollen Feet	Irregular Heart Beat	Cold Sweats
Palpitations	High Blood Pressure	Cold Hands	Cold Feet
Phlebitis	Other:		

MUSCULOSKELETAL

Neck Pain	Shoulder Pain	Injuries	Scoliosis
Arthritis	Muscle Spasms	Hip Pain	Weak Joints
Muscle Cramping	Recent Sprains	Joint Pain	Muscle Soreness
Hand/Wrist Pain	Knee Pain	Foot/Ankle Pain	Back Pain
Muscle Weakness	Other:		

GASTROINTESTINAL

Nausea	Constipation	Bad Breath	Belching
Hemorrhoids	Intestinal Gas	Diarrhea	Parasites
Vomiting	Indigestion	Blood in Stools	Black Stools
Bloating	Abdominal Pain	Gastric Ulcers	Other:

NEUROPSYCHOLOGICAL

Lack of Coordination	Dizziness	Depression	Stress
Poor Memory	Irritability	Disoriented	Light Headedness
Mood Swings	Headaches	Anxiety	Confusion
Easily Angered	Sadness/Grief	Overthinking	Worry
Loss of Balance	Easily Angered	Other:	

GENITO-URINARY

Painful Urination	Frequent Urination	Blood in Urine	Frequent Night Urination
Discolored Urination	Impotence	Inability to Hold Urine	Scanty Urination
Urgency	Urinary Tract Infections	Genital Sores	Kidney Stones

FEMALE GYNECOLOGY AND PREGNANCY

Irregular Periods	**Clotting**	**Painful Periods**	**Ab. Cramping**
Bloating	**Breast Tenderness**	**Heavy Flow**	**Light Flow**
Irritability	**Vaginal Discharge**	**Vaginal Sores**	**Painful Intercourse**

Any issues with fertility? ____
Any difficult labors (long, loss of blood, etc) ______________________________
Age of first menses ____
Date of last menses ____
# of Pregnancies _____
# of Births _____

MALE UROLOGY

Premature Ejaculation	**Painful Intercourse**	**Issues Maintaining an Erection**	**Failure to Reach Orgasm**
Lack of Desire	**Hernia**	**Discharge from Penis**	**Prostate Issues**
Sexual Anxiety			