



Keeping the U in Healthcare

Client Health and Wellbeing Intake Form

Name:	Email:	
Address:	City, State, Zip:	
Home Phone:	Other Phone:	
Cellular Phone:	Referred by:	
Date:	Date of Birth:	Age:

Part 1. Please answer the following questions to the best of your ability

Describe the problem(s) for which you seek help. Please include the dates when each problem occurred, and how long you have been experiencing the problem:

Please describe your past medical history (injuries, accidents, surgeries, illnesses, conditions) including approximate dates.

List the medications and supplements that you are presently taking, and the condition you are taking them for.

What daily activities are you finding difficult or are limited because of your above complaints?

What are your goals for the appointment?

Please list any other kind of health care professional you are seeing/have seen for this/these problem(s):

Please list any medical tests and results you have had within the past year:

Part 2. Please mark the symptoms that you experience

Digestion

- | | | | |
|---|--|--|--|
| <input type="radio"/> Loose stool or diarrhea | <input type="radio"/> Acid reflux | <input type="radio"/> Nausea/vomiting | <input type="radio"/> Poor appetite |
| <input type="radio"/> Constipation | <input type="radio"/> Heartburn | <input type="radio"/> Difficulty digesting oil | <input type="radio"/> Excessive appetite |
| <input type="radio"/> Gas or belching | <input type="radio"/> Stomach or intestinal pain | <input type="radio"/> Blood in stool | <input type="radio"/> Other: |

Respiratory

- | | | | |
|---------------------------------|---|---|---|
| <input type="radio"/> Allergies | <input type="radio"/> Catch colds easily | <input type="radio"/> Sinus problems | <input type="radio"/> Do you smoke? |
| <input type="radio"/> Asthma | <input type="radio"/> Congestion nasal or chest | <input type="radio"/> Shortness of breath | <input type="radio"/> Number per day_____ |
| <input type="radio"/> Dry cough | <input type="radio"/> Wheezing | <input type="radio"/> Chest tightness | <input type="radio"/> Nose bleeds |
| <input type="radio"/> Wet cough | <input type="radio"/> Other: | | |

Circulation Cardiovascular

- | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="radio"/> High blood pressure | <input type="radio"/> Slow heart rate | <input type="radio"/> Too hot | <input type="radio"/> Dizziness |
| <input type="radio"/> Low blood pressure | <input type="radio"/> Chest pain | <input type="radio"/> Too cold | <input type="radio"/> Water retention |
| <input type="radio"/> Fast heart rate | <input type="radio"/> Palpitations | <input type="radio"/> Cold hands/feet | <input type="radio"/> Other: |

Urinary

- Painful urination Incontinence Difficulty urinating Kidney stones
 Kidney infections Other:

Other

- Difficulty learning Numb/tingling. Where? _____ Thirsty Poor sense of taste
 Difficulty paying attention Muscle weakness No thirst poor sense of smell
 Difficulty with speech Difficulty walking Dry mouth Poor hearing
 Development/growth issues Shaky Difficulty swallowing Fatigue
 Poor coordination Dry eyes Anemia Insomnia
 Loss of balance Eye pain Eczema Lots of sleep. No hours? ____
 Headaches Watery eyes Skin condition Nightmares
 Migraines Poor vision Joint swelling Nose bleeds
 Abdomen/thorax pain Other eye problems? Other

Women Only

- Breast pain or tenderness Are your cycles regular? Length of cycle: Painful menses
 Heavy or excessive flow PMS Other:

Part 3. Wellbeing, Emotions and Stress

a: Please circle any of the following feelings you have experienced in the past few months.

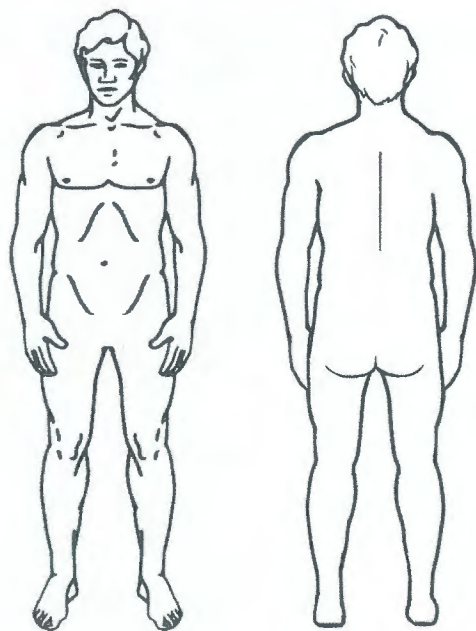
b: Please mark your level of stress from the listings below.

- | | | | |
|-----------|------------|------------------|------------|
| Emotional | Paranoid | Apprehensive | Annoyed |
| Despair | Muddled | Overwhelmed | Outraged |
| Helpless | Grief | Intimidated | Obsessive |
| Uneasy | Nervous | Depressed | Indecisive |
| Distress | Worried | Easily Irritated | Intolerant |
| Fearful | Restless | Unable to Grieve | Paralyzed |
| Angry | Criticized | Overworked | Hopeless |
| Panic | Rejected | Persecuted | Anxious |
| Guilt | Agitated | Aggravated | Abused |
| Sad | Impatient | Uncertainty | |

- Family stress is: None Minimal Moderate Severe
Relationship stress is: None Minimal Moderate Severe
Work stress is: None Minimal Moderate Severe
Financial stress is: None Minimal Moderate Severe
Health stress is: None Minimal Moderate Severe
Other stress is: None Minimal Moderate Severe

Part 4. Pain.

Please mark areas of pain/discomfort on the body diagrams and make comments on the side if necessary.



Comments:

Client Signature:

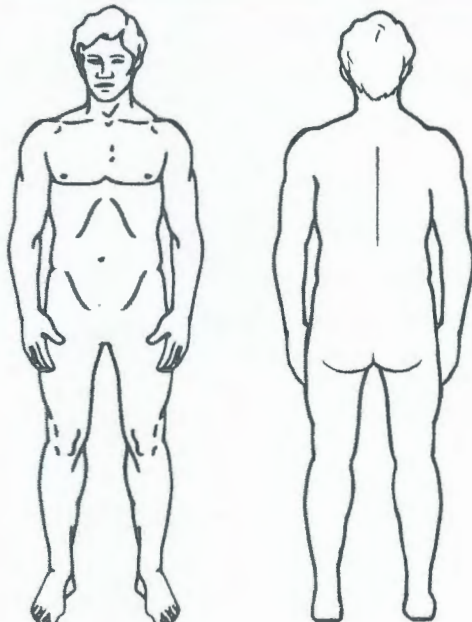
Date

Part 5 Practitioner to complete

List the notable symptoms with rating on a scale of 1-10. 1. Slight awareness of symptom. 3. Awareness of symptom as an aggravation. 5. Strong pain/symptom but still functional. 7. Strong pain/symptom unable to function. 10. Very serious, unbearable, take me to the emergency room.

Notable Symptoms	Comments – How often, when, where?	Rating
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
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		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Comments and Notes



A series of 18 horizontal lines provided for the practitioner to write their comments and notes.

Practitioner signature:

Informed Consent Form



Please read carefully and sign below

I understand that the Accunect sessions offered by

_____ are not a replacement for medical treatment when necessary.

I understand that the purpose of the sessions is to increase my own conscious and subconscious awareness of areas where my body can manage its own self-healing process more effectively on all levels, mind body and spirit.

I also understand that no medical diagnosis or prognosis of recovery can be given on the basis of consciousness based healing and Accunect. Therefore, I will not interpret any statements by the above named practitioner as a diagnosis or prognosis of my condition.

By signing my signature below I agree to sessions from the above named practitioner with this understanding.

Print Name of Client: _____
(For yourself or your child if under 18 years of age)

Signature: _____ **Date:** _____

Print Name on Signature: _____
(If different from client)