Misty Fall Body Works
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Amma Therapy Client Intake Form

Name:____Today's Date ____/___/___
Age:______________________M / F / Other___________________________________

Birthdate:___/___/___ Address ___________________________________ City ___________
State______ Zip _________ Email____

Home/Cell Phone ___________________________

Occupation ________________________________ Do you like your work? ______________

Weight __________Height __________ date of last medical exam _____/_____/_________
How did you hear about Misty Fall Body Works? _____________________________________

A. Concerns/Goals

What are your major concerns? (list all symptoms, location, and type of pain or discomfort in order of importance.)

1. ____
2. ____
3. ____

Date problem began _______________ _______________ _________________________

What are your health and wellness goals?

1.____
2.____

B. History

Have you ever had surgery? If so what kind?

____

____

Have you ever been in a car accident or suffered any other type of physical trauma?
If so when? Please list what kind of treatment you received:

____

____

Is there any mental/emotional history I should be aware of?

____

____

____

C. Medication/Libations

List all drugs (prescription and non-prescription), vitamins, minerals, herbs or other vitamin supplements that you are presently taking on a regular basis. The dosage, duration and reason for taking should be included:

Name ____

____

Dosage/Duration____

____

Reason for taking____

____

How often do you smoke tobacco? _____daily _____ weekly ___few times a month /year
____never_____

How often do you smoke marijuana? ____daily ____ weekly ____ few times a month / year
_____ never_______

How often do you use alcohol? _____daily _____weekly ____ few times a month /year
_____never _________

When you consume alcohol, how much do you usually consume? _______________________

Do you mostly drink, _____Beer _____Wine/Cider _____ Hard liquor / Mixed drinks

D. Food

Is there any dietary philosophy that you follow?

____

Favorite foods? ____

Food Sensitivities / allergens? ____

24-hour recall – What did you eat and drink yesterday?

Breakfast____

Drink____________________________________Snack_______________________________

Lunch____________________________________Snack_______________________________

Dinner___________________________________Snack/Drink__________________________

Do you experience indigestion / loose stools / constipation / acid reflux / excessive gas or burping?

Anything else about your diet you think would be helpful to know?

____

____

Do you have a menstrual cycle? Yes / No

If yes, please answer the following: Do you suffer PMS symptoms? Yes / No

What Kind (bloating, cramping, migraine, irritability, sensitive breasts, etc.)?

____

Do you suffer Premenopausal symptoms (hot flashes, night sweats, etc.)? Yes / No What Kind?

____

How long does your cycle last? (#days bleeding & #days in cycle)

____

Are you regular? ____