Male Confidential Client Intake Form

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Name:_____**Date of Initial Visit**_____

Address_____**City/State**_____**Zip**_____

Phone_____**email**_____

Date of Birth_____**Age**_____**Occupation**_____

Marital/Relationship status_____**Referred by**_____

Have you had massage/bodywork before?_____ **What type?**_____

Reason For Visit

Primary reason for visit:_____

When did your first notice it?_____**What brought it on?**_____

Describe any stressors occurring at the time_____

What activities provide relief?_____**What makes it worse?**_____

Is this condition getting worse?_____**interfere with work**_____**sleep**_____ **recreation**_____

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made other wise.
I agree to give at least 24 hour notice of cancellation of appointment.
I understand the treatment here is not a replacement for medical care.
I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice)
As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations.
I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature_____Date_____

Therapist/Practitioner signature:_____Date_____

Medical History

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____

Name(s) of Practitioner_____Address:_____

Phone_____email_____

Current Medications and /orSupplements/Remedies:_____

_____

Allergies: specify allergen and reaction:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Hospitalizations

_____

_____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe)_____

Please review and check the following:

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Digestion and Elimination

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____**Water Intake(glasses/day)**_____**Caffeine**_____

What is the worst item in your diet_____**What foods are your weakness**_____

Are you subject to binge eating?_____**What foods**_____

Do you experience bloating/gas/burps after eating?_____**What foods trigger this?**_____

How often are your bowel movements?_____**Do your stools: sink**_____**float**_____

Constipation?_____**Blood in stool ?**_____**Mucus in stool?**_____**Pain when stooling?**_____

Do you use Tobacco?_____ **Quantity**_____**/ppd Alcohol?**_____**Quantitiy**_____**ounces/ day**

Marijuana?_____**Quantity**_____**Other:**_____**Have you been under treatment for substance use?**

Other :

EMOTIONAL & SPIRITUAL

What is your opinion of yourself?_____

If possible, please describe the most negative emotion you experience_____

When do you most often feel this emotion_____**Where are you?**_____

Do you pray to or have a spiritual practice_____

On a scale of 1 – 10 ***(1 being the lesser, 10 the greater*****) Please rate yourself:**

Faith_____**Hope**_____**Charity**_____**Generosity**_____ **Sense of Humor**_____
Sense of Fun_____**Fear**_____**Grief**_____**Other (describe briefly)**_____

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment_____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months_____**One Year**_____

MALE ~ REPRODUCTIVE HEALTH HISTORY

Check and **Describe** those symptoms as **applicable**

Headaches: Migraine_____Tension_____Cluster_____Low back pain_____Sore heels_____
Varicose Veins _____ Location_____ Numbness in legs/feet _____

Family History of Prostate Disease:____Type_____Relationship_____

Family History of Cancer_____Type_____Relationship_____

History of sexually transmitted disease_____When_____Type_____

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____trauma_____incest__If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

Urinary Symptoms (circle or check those applicable)

Painful urination _____Bladder/Kidney infections _____
Frequent Urination _____ Nocturnal Urination/ Frequency_____
Changes in urinary stream (describe flow, stream, strength of stream)_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Erectile Function(describe as indicated)

Difficulty obtaining an erection_____Difficulty maintaining an erection _____Painful ejaculation _____

Is there a history of back injury/trauma_____Describe_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Current Medications or Supplements:_____

_____

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

AdditionalComments:

Notes for session: