Coaching the Body Session

Practitioner: Alexandra Connors

Uproot Progress Intake Form

Name:_____ Age:_____ Birth Date:_____

Address: _____ City:_____ Zipcode:_____

Work/Cell: _____ Email: _____

Emergency Contact: _____ Phone:_____

Referred By: _____

Medical History

Height :_____ Weight: _____ Are you currently under the care of a physician? ___Yes___No

If yes, what for? _____ Are you currently under the care of an alternative medicine practitioner? Yes/No

If yes, what for? _____

Please check any of the following that apply to you (in the past or currently):

___ Heart problems ___ Arthritis ___ Back problems ___ High blood pressure ___ Osteoarthritis ___ Spinal problems ___ Blood clots ___ Wear contact lenses ___ Disc problems ___ Varicose veins ___ Pregnant ___ Joint problems ___ Pacemaker ___ Diabetes ___ Accidents or Injuries ___ Neurological problems ___ Surgery ___ Major illness or disease ___ Headaches ___ Epilepsy or Seizures ___ Recent breaks/sprains ___ Sinus problems ___ Digestive problems ___ Skin problems ___ Circulatory problems ___ Constipation ___ Respiratory problems

Has your physician told you that you have any of the following?

__Herniated/bulging disks __Spinal Stenosis __Scoliosis __Diabetes __Thyroid Problem

Do you use any other body therapies?

___Chiropractic ___Massage ___Physical Therapy ___Acupuncture ___Tens Unit

Other: _____

What do/did you use the therapy for? _____

Medications:

List any medication you currently take:

_____

List any medication you have used in the past three years and why you stopped taking it:

_____

_____

_____

List any vitamins, minerals, supplements that you take:

_____

Pain History

Describe any pain/tension. How long have you had it?

_____

_____

_____

Was there an event or illness that seemed to start it?

_____

Is your pain/tension worse in the morning or evening?

_____

Does anything seem to change your pain? Make it worse/better?

_____

Are there particular movements associated with your pain?

_____

Please list any accidents, surgeries, etc. starting with the most recent.

_____

_____

_____

Jaw/Facial Pain: Do you have TMJ? ___Yes ___No

Do you have jaw pain associated with chewing or yawning? ___Yes ___No

Do you clench or grind your teeth? ___Yes ___No Do you wear a night guard? ___Yes ___No

When was your last dental appointment? _____

Do you wear bifocals or progressive lenses? ___Yes ___No

Do you or have you ever experienced any visual disturbances? ___Yes ___No

If yes, please explain?_____

When was your last eye doctor appointment? _____

Lifestyle

Do you have child-care or other home-tasks? ___Yes ___No

Are you immobile for long periods of time? ___Yes ___No

Of these words, which best describe your home environment:

___Safe ___Supportive ___Stable ___Whole___Disorienting___Unsafe___Challenging___Tense

Other? :

Are you able to work? ___Yes ___No

What is your occupation?

_____

Does your pain affect your work?

_____

Do you perform repetitive movements at work?

_____

Activities/Hobbies: List any activities/hobbies you do on a regular basis? (musical, sport, sewing, gardening, etc.)

_____

_____

_____

Exercise: Are you able to exercise? ___Yes ___No

What type of exercise do you enjoy doing?

_____

Sleep: How many hours of sleep do you typically get? _____ Do you experience any of the following?

___Difficulty Falling Asleep ___Waking Often ___Waking Unrefreshed

What position do you sleep in?

___Back ___Side ___Stomach ___Arms Overhead ___Half-Stomach/Half-Side ___Fetal Position ___Spooning

If you sleep on your back, do you put pillows under your knees? ___Yes ___No If you sleep on your side, do you put pillows between your legs? ___Yes ___No At your chest? ___Yes ___No

Substances: Do you drink alcohol? ___Yes ___No

What kind and how often?

_____

Do you smoke tobacco products or consume nicotine? ___Yes ___No

What kind and how often?

_____

Do you consume other drugs recreationally? ___Yes ___No

What kind and how often?

_____

Do you drink caffeinated beverages? ___Yes ___No

What kind and how often?

_____

Do you frequently eat foods with high amounts of sugars/carbohydrates? ___Yes ___No

What kind and how often?

_____

Wide Lens

What are your goals regarding your overall quality of life?

1. _____

2. _____

3. _____

4. _____

How committed are you currently, on a scale of 1-10, to pursuing these goals, given that it will require you to break habits, dedicate time and resource? Why?

_____
_____
_____

Can you identify obstacles that might challenge or complicate your pursuit of these goals?

1. _____

2. _____

3. _____

Given these obstacles, can you identify three assets or supportive factors that will aide you along the way?

1. _____

2. _____

3. _____

I understand that the purpose of Thai Bodywork is for relaxation and that it is not meant to diagnose illness, disease or any other physical or mental disorder, injury or condition. I have informed my practitioner about my state of health and any recommendations and restrictions on the part of my medical doctor or therapist. I understand that if I cancel a session less than 24 hours in advance I will be billed for the session.

Client Signature

X _____ Date: _____