



# The Healing Tree (406) 585-1375

## 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:

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

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

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

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What are your goals for the appointment?

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

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

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### 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:          |

