Centered Spirit

Thank you for taking the time to fill out this questionnaire. It is somewhat lengthy but important to our overall treatment success. This information will be held in the strictest confidence.

Personal Information

Name_____ Sex: Male or Female Date of Birth_____

Address _____ City_____ State_____ Zip _____

Home Phone _____ Business or Cell Phone _____ Occupation_____

Employer_____ Emergency Contact_____ Phone (Day) _____ (Eve) _____

Marital Status _____ If not married do you have a significant other _____ Do you have children _____ ages _____

E-mail _____How did you hear about ***Centered Spirit?*** _____

Background Information

Have you had massage or bodywork before? (If so, where, when, what type, frequency) _____

_____

Do you exercise regular, participate in sports or yoga? (If so, what type and frequency) _____

Do you stretch? (If so, number of times per week) _____

Specific Complaints

What is your major area of pain or concern? _____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____

At or around the time of the onset were there other emotional stresses occurring? _____

Is this condition getting worse? _____ Does it interfere with work? _____ sleep_____ recreation_____

What have you done to get relief? _____

Have you sought a diagnosis? _____ By whom? _____ Diagnosis_____

Other areas of pain or concern _____

Stress Level

What is you current stress level? (low) 1 2 3 4 5 (high) Is the stress positive, negative or both? _____

How many hours of sleep do you get in an average night? _____

Do you usually wake feeling rested? _____ Tired? _____ Other? _____

Anxiousness: Often Sometimes Seldom Explain _____

Depression: Often Sometimes Seldom Explain _____

Digestion and Diet

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Snacks _____

How many times a week do you dine out? _____

How many times a week do you have:

Beef	_____	White Rice	_____	White Bread	_____	Soda pop	_____
Pork	_____	Chicken	_____	Fish	_____	Ice Cream	_____
Desserts	_____	Candy	_____	Milk	_____	Other Dairy	_____
Chips	_____	Canned Food	_____	Fruit	_____	Veggies	_____
Organic Products	_____	Whole Grains	_____	Alcohol	_____	Caffeine*	_____
Tobacco	_____	Recreational Drugs	_____	Pasta	_____	*Coffee, Teas, Colas	

How many glasses of water per day? _____

Do you prefer Ice Cold Drinks or Hot Drinks? _____

How is your appetite? _____

Do you crave certain foods? (what, when, do you actually go get it?) _____

How do you feel about your diet? _____

What would you say is the worst thing about your diet? _____

How is your digestion? (Bloating? Sour burps? Heartburn? Gas? Etc.) _____

Are you on a restricted diet? (type of foods, frequency of eating)? _____

Bowel movements (circle what applies): Daily Regular schedule Irregular schedule Constipation (frequency _____) Hard Stools Soft Stools

Urination (circle what applies): Normal Scanty Frequent Burning Strong Odor Dark Color

Any history of bladder or kidney infections? (If so please list age also) _____

Family History

	Still Living?	Age/Cause of Death	Major ailments
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			
Father			

Optional: Is there a history of abuse in your family? _____ (circle what applies) emotional physical sexual spiritual drug alcohol

_____

Is there a history of suicide in your family? _____

Emotional and Spiritual

Are you romantically involved? _____ How is your relationship? (Is it satisfying?) _____

Were there any emotional traumas in your early or present life? (rape, great loss, suicide, death, change of life style, etc.) _____

_____

If possible, please explain any negative emotion you may experience _____

When do you feel this emotion? Where are you when you feel this? _____

What is your opinion of yourself? _____

Have you ever been to counseling? (If so, what was outcome?) _____

Do you put time or energy into a relationship with a higher power? _____

Do you meditate? (If so, how often?) _____

How do you rate yourself on (For example, None, Some or Lots):

Faith	_____	Hope	_____	Charity	_____	Generosity	_____
Sense of Humor	_____	Sense of Fun	_____	Self Care	_____	Self Love	_____

Is there an unrealized longing in your life? (If so, what is it and what would fulfill it) _____

_____

Are you involved in activities outside of work? (Social, recreational, sports, etc./frequency) _____

Hobbies or interests? _____

Birth and Early Childhood

Circle the type of birth you had: Normal Difficult Trauma at Birth Unknown Additional Notes: _____

Explain your ***early*** relationship with **each** of your parents _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Explain your ***present*** relationship with **each** of your parents _____

_____

_____

_____

_____

_____

_____

_____

Medical History

Are you currently under the care of a doctor, chiropractor or other health care practitioner? (include their names & locations) _____

_____

If so, for what conditions and when did you last see them? _____

_____

List any medications, herbal remedies, supplements, over-the-counter medications that your are taking (including frequency) _____

_____

Do you have any allergies in general or to specific medications? (If so, please explain) _____

Any Broken bones? (include year) _____

Any Surgeries? (include year) _____

Any other trauma or hospitalizations? (include year) _____

Any medications you took as a child? (include year and duration) _____

Childhood accidents or physical traumas? _____

Have you ever hit or fallen on your tailbone? _____

Circle any of the following you are ***CURRENTLY*** experiencing and Underline any you have had as a ***PAST*** problem:

Headaches	Ringing in ears	Pins & needles in arms/hands	Pins & needles in legs
Shooting pain in head	Asthma	Cold hands	Cold feet
Sinus trouble	Epilepsy or other seizures	Heart pain	Swollen ankles
Loss of smell	Muscle spasm in neck	Blood clots, phlebitis	Pain in legs and feet
Loss of taste	Tingling in neck	Skin disorders, acne, fungus, rash	Sciatica
Tightness in throat	Tightness in shoulders	Painful joints	Numb hands/feet
Face flushed	Painful menstruation, cramps	Swollen joints	Constipation
Loss of memory	Contact lenses	Pins & needles in back	Allergies
Fatigue	Sensitivity to oils and lotions	Herniated or bulging disk	High or low blood pressure
Depression	Lung or breathing problems	Pinched neck in back	Spinal problems
Head feels too heavy	Pregnancy	Arthritis, osteoporosis, brittle bones	Varicose veins/circulatory problems
Diabetes	Fainting spells	Hepatitis	Emotional problems
Frequent flu or cold	Anorexia/Bulimia	Cancer	Bad Breath
Heart problems	Kidney problems	Swollen prostate	HIV

For Women Only

Are you currently pregnant or trying to become pregnant? (If so, please list week number, general status, any other important information) _____

_____

How many pregnancies have you had? _____ Number of deliveries _____ Were there any complications? _____

_____

What was pregnancy, labor and delivery like for you? _____

Did you nurse your babies? (If so, what was your impression of that experience?) _____

List any Advanced Reproductive Technology (ART) procedures (IUI, IVF,etc.) you have had or are currently undergoing for fertility_____

_____

Have you had any miscarriages? _____

Have you had any abortions? (If so, when?) _____

What medications did your mother take when she was pregnant with you? _____

Circle any of the following situations that the women on your mother's side of the family have?

Infertility	Menstrual problems	Difficult childbirth
Difficult menopause	Cancer	Heart trouble

Circle any of the following situations that describe your menstrual pattern:

Painful periods	Late, early or irregular	Dizziness with period
Dark, thick blood at onset/end of menstruation	Excessive bleeding (more than one pad/hour)	Headache or migraine with period
Blood clots during menstruation	PMS/Depression with or before period	Failure to ovulate regularly
Painful ovulation	Bloating or water retention with period	

Do you experience heaviness in the lower pelvis as menses begins? _____

How many days does your period last? _____ Date of your last period _____

Do you experience no periods at all? (If no periods, please explain) _____

Circle any of the following signs or symptoms that apply:

Varicose veins of the legs	Numb legs & feet, especially when standing still	Tired weak legs
Sore heels when walking	Low back ache	Painful intercourse
Constipation	Endometriosis	Endometritis
Uterine polyps	Uterine Fibroids	Uterine infections
Frequent urination	Bladder infections	Vaginal discharge (what color) _____
Vaginal yeast conditions/vaginitis	Chronic miscarriages	Premature deliveries
Weak newborn infant	False pregnancies	Pelvic inflammation
Sexually transmitted disease	Difficult pregnancy, incompetent uterus, spotting	Difficult menopause
Ovarian or breasts cysts	Cancer of the cervix, uterus, bladder or lower bowel	Dry vagina with or without menopause

List any other signs or symptoms not included on list: _____

_____

Do you remember if you had any serious falls or accidents? (Explain and list age) _____

Are you now or have you ever taken birth control pills? (If so, when and for how long) _____

Do you have or have you ever had fertility problems? _____

Have you presently or recently been under a doctor's care for gynecological problems? _____

Rate your interest in sex: High Moderate Low None

Do you have difficulty achieving orgasms? (If so, explain) _____

Were you ever raped? (If so, at what age did this occur) _____

Are you a survivor of incest? (If so, at what age) _____

If you did experience rape or incest, did you receive counseling for this? (If so, what was the counseling like for you? Did it help?) _____

_____

Have you experienced a period every two weeks within the past few years? _____

If Menopause applies, please circle applicable symptoms or situations and list approximate age when they began:

Hot Flashes	Memory loss	Insomnia
Mood swings	Vaginal discharge (color) _____	Fatigue
Depression	Estrogen replacement therapy (for how long) _____	

List any herbal remedies, vitamins, supplements, fertility drugs, or natural products you are presently taking _____

_____

_____

For Men Only

Circle any of the following signs or symptoms that apply.

Painful urination	Bladder / Kidney infections	Difficulty obtaining an erection	Painful ejaculation
Frequent urination	Nocturnal urination	Difficulty maintaining an erection	Swollen prostate / prostatitis
Low sperm count	Low sperm motility	Irregular sperm morphology	Sexually transmitted disease

When did you first notice these symptoms? _____ Are they getting better or worse, describe_____

_____

Current medications, supplements or treatments_____

Family history of prostate disease_____Type_____Realationship_____

Please Read and Sign

I have completed this information form to the best of my knowledge. I understand that massage/bodywork services are designed to be a health aid and are in no way to take the place of a doctor's care when indicated. I understand that massage therapists/bodyworkers are not qualified to perform spinal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session(s) will be construed as such. The therapist or client reserves the right to end the session at any time if massage/bodywork is contraindicated. Information I receive during any session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Signature_____ Date_____