Catherine Henderson
New Client Intake Worksheet
Vashon

Last Name________________________________ First Name ______________________

Address____

City___________________________________State__________Zip____________________

Phone:(Home)_________________(Work)___________________ (Cell)___________________

Age_____Date of Birth _____/______/______ Email _______________________________

Referred by: ____

Patient's condition____
____
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Duration of Problem ____

Doctor __________________________________ Doctor's Telephone ___________________

No. in household ______________ Occupation __________________________________

For Child Only: Parent or guardian ____

Occupation Parent 1: _______________________ *Parent 2:* ________________________

Emergency Contact (name & phone)
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VASHON FEES

- **New clients**: Initial visit $205 Child under 14 $130
- **Follow-ups**: Adult $145, Child under 14 $90

($5 discount on follow-ups with cash or check)

OFFICE POLICIES

- 24-hours or one business day cancellation notice so **Monday appointments to be canceled on Friday**.
- For "no-shows" and late cancellations, you are charged the treatment fee
- We do not take any insurance.
- Payment is required at the time of your visit. We accept cash, check credit or Paypal.

I have read and agree to honor all office policies.

Signed____ Date ______________________

HEALTH QUESTIONNAIRE

FAMILY HISTORY – Did any blood relative suffer any of the following? Please highlight and indicate which relative:

- Epilepsy
- Migraine
- Mental Illness
- Glaucoma
- Diabetes
- Thyroid
- Hayfever
- Asthma
- Anemia
- Bleeds easily
- Osteoporosis
- Arthritis
- Heart disease
- Hypertension
- High cholesterol
- Alcoholism
- Hepatitis
- Cancer

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HOSPITAL ADMISSIONS	YEAR	ILLNESS or OPERATION	YEAR	ILLNESS or OPERATION
Medications/ Supplements		**ALLERGIES**	**VACCINE**	**TEST EXAM**
			Covid__________	○ Rectal/Stool _______
			Date of last	○ Cholesterol ________
			booster ________	○ Eye Exam _________
				○ TB Test ___________
				○ Hepatatis _________

MEDICAL HISTORY

❒ Decreased hearing
❒ Ringing in ear
❒ Ear infections
❒ Dizzy or fainting spells
❒ Failing vision or eye pain
❒ Double or blurred vision
❒ Nose bleeds – recurrent
❒ Sinus trouble
❒ Sore throats – frequent
❒ Hoarseness – prolonged
❒ Hayfever /Allergies
❒ Pneumonia / Pleurisy
❒ Bronchitis / Chronic cough
❒ Asthma / Wheezing
❒ Shortness of breath
❒on exertion ❒lying flat
❒ Chest pain
❒ High blood pressure
❒ Heart murmur
❒swollen ankles
❒irregular pulse ❒palpitations
❒ Leg pain - when walking
❒ Varicose veins / Phelebitis
❒ Cold numb feet
❒ Loss of appetite - recent
❒ Difficulty swallowing
❒ Heartburn ❒Peptic ulcer
❒ Persistent Nausea / Vomiting
❒ Abdominal Pain - chronic
❒ Gallbladder trouble
❒ Jaundice / Hepatitis
❒ Diarrhea ❒Constipation
❒ Diverticulosis ❒Crohn’s / Colitis

❒ Inflammatory Bowel Syndrome
❒ Bloody or tarry stool
❒ Hemorrhoids ❒Hernia
❒ Urination / Overactive bladder
❒Overnight more than twice
❒More than 8 times / 24 hrs
❒Urgency to urinate
❒with leakage
❒ Decrease in force/flow ❒ painful
❒ Stress incontinence – urine leakage with exercise /movement
❒ Blood in urine ❒Kidney stones
❒ Urine infections – frequent
❒ Sexually transmitted diseases
❒ Sexual problems
❒ Weight loss ❒Gain – recent
❒ Anemia ❒Bruise easily
❒ Blood transfusions
❒ Cancer ❒Chronic fatigue
❒ Diabetes ❒Thyroid disease
❒ Seizures ❒Stroke
❒ Tremor / hands shaking
❒ Numbness / tingling sensations
❒ Headaches – frequent
❒ Arthritis / Rheumatism
❒ Back pain – recurrent
❒ Bone fracture / joint injury
❒ Osteoporosis
❒ Foot pain ❒Gout
❒ Rashes ❒Hives
❒ Psoriasis ❒Eczema
❒ Any type of sleeping difficulty
❒ Depression ❒Nervousness

❒ Agitation ❒Memory loss
❒ Moodiness ❒ Suicidal thoughts
❒ Phobias ❒Mental illness
❒ Feelings of worthlessness
❒ Rheumatic fever ❒Scarlet fever
❒ Chickenpox ❒Polio ❒Mumps
❒ Measles ❒German measles
❒ Tuberculosis ❒Herpes
❒ AIDS / HIV
❒ Alcohol ____ oz/week
❒ Coffee / Tea ____cups per day
❒ Smoking _____cig/day
years ____ year quit_____
❒ Exercise ___________________
❒ Street drugs ________________
❒ Acupuncture / tattoos
❒ Hair loss _ progressive _ recent

MALES: ❒ Prostate problems

FEMALES *Please complete:*

Menstrual Flow:
❒Regular ❒ Irregular ❒ Pain/Cramps
Days of flow _____ Length of cycle ____
Date of 1st day of last period ___________
❒Pain / Bleeding during or after sex
Number of Pregnancies _____
Abortions _____ Miscarriages _____
Live Births _____
Birth control method _________________
❒ Flushing / Menopause
Date of last PAP test _________________
❒Normal ❒Abnormal
Date of last mammogram _____________
❒Normal ❒Abnormal