

Catherine Henderson
New Client Intake Worksheet
Vashon, WA

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Phone:(Home) _____ (Work) _____ (Cell) _____

Age ____ Date of Birth ____ / ____ / ____ Email _____

Referred by: _____

Patient's condition _____

Duration of Problem _____

Doctor _____ Doctor's Telephone _____

No. in household _____ Occupation _____

For Child Only: Parent or guardian _____

Occupation Parent 1: _____ *Parent 2:* _____

Siblings _____

Emergency Contact (name & phone)

Fees:

- **New clients:** Long initial visit \$200 , regular second visit \$120 **OR**
 - Short initial visit \$120 (includes treatment) , long second visit \$160-\$200
 - depending on complexity
 - New Child under 14 - \$120
 - **Follow-ups:** Adult - \$120, Child under 14 - \$80
- (\$5 discount on follow-ups with cash or check)

Office Policies:

- 24-hours (1 business day) cancellation notice
- For “no-shows” and late cancellations, you are charged half of treatment fee
- We do not take any insurance.
- Payment is required at the time of your visit. We accept cash, check or credit

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:

- | | | | |
|--------------------------------------|-------------------------------------|--|----------------------------------|
| <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid | <input type="radio"/> Osteoporosis | <input type="radio"/> Alcoholism |
| <input type="radio"/> Migraine | <input type="radio"/> Hayfever | <input type="radio"/> Arthritis | <input type="radio"/> Hepatitis |
| <input type="radio"/> Mental Illness | <input type="radio"/> Asthma | <input type="radio"/> Heart disease | <input type="radio"/> Cancer |
| <input type="radio"/> Glaucoma | <input type="radio"/> Anemia | <input type="radio"/> Hypertension | _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Bleeds easily | <input type="radio"/> High cholesterol | _____ |

HOSPITAL ADMISSIONS	YEAR	ILLNESS or OPERATION	YEAR	ILLNESS or OPERATION
Medications/ Supplements		ALLERGIES	VACCINE	TEST EXAM
			Tetanus/TD ____	<input type="radio"/> Rectal/Stool _____
			Flu _____	<input type="radio"/> Cholesterol _____
			Pneumonia ____	<input type="radio"/> Eye Exam _____
			Hepatitis _____	<input type="radio"/> TB Test _____
				<input type="radio"/> Hepatitis _____

MEDICAL HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Ringing in ear
<input type="checkbox"/> Ear infections
<input type="checkbox"/> Dizzy or fainting spells
<input type="checkbox"/> Failing vision or eye pain
<input type="checkbox"/> Double or blurred vision
<input type="checkbox"/> Nose bleeds – recurrent
<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Sore throats – frequent
<input type="checkbox"/> Hoarseness – prolonged
<input type="checkbox"/> Hayfever /Allergies
<input type="checkbox"/> Pneumonia / Pleurisy
<input type="checkbox"/> Bronchitis / Chronic cough
<input type="checkbox"/> Asthma / Wheezing
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> on exertion <input type="checkbox"/> lying flat
<input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> swollen ankles
<input type="checkbox"/> irregular pulse <input type="checkbox"/> palpitations
<input type="checkbox"/> Leg pain - when walking
<input type="checkbox"/> Varicose veins / Phelebitis
<input type="checkbox"/> Cold numb feet
<input type="checkbox"/> Loss of appetite - recent
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Persistent Nausea / Vomiting
<input type="checkbox"/> Abdominal Pain - chronic
<input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> Jaundice / Hepatitis
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis | <input type="checkbox"/> Inflammatory Bowel Syndrome
<input type="checkbox"/> Bloody or tarry stool
<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia
<input type="checkbox"/> Urination / Overactive bladder
<input type="checkbox"/> Overnight more than twice
<input type="checkbox"/> More than 8 times / 24 hrs
<input type="checkbox"/> Urgency to urinate
<input type="checkbox"/> with leakage
<input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> painful
<input type="checkbox"/> Stress incontinence – urine
leakage with exercise /movement
<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones
<input type="checkbox"/> Urine infections – frequent
<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Weight loss <input type="checkbox"/> Gain – recent
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
<input type="checkbox"/> Tremor / hands shaking
<input type="checkbox"/> Numbness / tingling sensations
<input type="checkbox"/> Headaches – frequent
<input type="checkbox"/> Arthritis / Rheumatism
<input type="checkbox"/> Back pain – recurrent
<input type="checkbox"/> Bone fracture / joint injury
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout
<input type="checkbox"/> Rashes <input type="checkbox"/> Hives
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema
<input type="checkbox"/> Any type of sleeping difficulty
<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness | <input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss
<input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness
<input type="checkbox"/> Feelings of worthlessness
<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Measles <input type="checkbox"/> German measles
<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes
<input type="checkbox"/> AIDS / HIV
<input type="checkbox"/> Alcohol ____ oz/week
<input type="checkbox"/> Coffee / Tea ____ cups per day
<input type="checkbox"/> Smoking ____ cig/day
years ____ year quit ____
<input type="checkbox"/> Exercise _____
<input type="checkbox"/> Street drugs _____
<input type="checkbox"/> Acupuncture / tattoos
<input type="checkbox"/> Hair loss _ progressive _ recent
MALES: <input type="checkbox"/> Prostate problems
FEMALES <i>Please complete:</i>
Menstrual Flow:
<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps
Days of flow ____ Length of cycle ____
Date of 1 st day of last period _____
<input type="checkbox"/> Pain / Bleeding during or after sex
Number of Pregnancies ____
Abortions ____ Miscarriages ____
Live Births ____
Birth control method _____
<input type="checkbox"/> Flushing / Menopause
Date of last PAP test _____
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date of last mammogram _____
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
|--|--|--|