



Stacy Earlywine
Structural Medicine

Client Intake Form

Confidential

Personal Information

Name: _____ Phone: _____

Address: _____

Age: _____ DOB: _____ Height: _____ Weight: _____ lbs

Email: _____ Date of Intake: _____

Occupation: _____ Referred by: _____

Emergency contact: _____ Relationship: _____

Phone: _____

Bodywork Experience

Are you here for Injury treatment Wellness Have you had bodywork before? yes no
If yes, what type? Structural Integration Massage Other

Health History

Please check anything that applies now or has applied at any point in your life, even if you think it's not likely relevant to the current issue for which you seek treatment. For any checked issues, please provide a short explanation or more information.

Musculoskeletal

- back pain
- disc problems
- tendonitis
- bursitis
- arthritis
- jaw pain
- lupus
- osteoporosis
- scoliosis
- broken bones
- migraines/headaches

Circulatory

- heart condition
- varicose veins
- high/low blood pressure
- lymphedema
- thrombosis (clotting issues)

Respiratory

- breathing difficulty
- asthma
- emphysema
- sinus problems

Nervous System

- shingles
- numbness/tingling
- chronic pain
- paralysis
- MS
- Parkinson's disease

Reproductive

of pregnancies _____ # of live births _____
of c-section births _____ currently pregnant? _____
 ovarian/menstrual problems other

Skin

- scars
- rashes
- cosmetic surgery
- athlete's foot
- other

Digestive

- digestion or GI problems
- bladder/kidney

Psychological

- anxiety
- depression
- stress

Other

- cancer/tumors
- car accidents
- diabetes
- contact lenses
- dentures
- hearing aids
- surgeries

Please list any other medical condition(s) not listed:

Current Health

- Do you exercise regularly and/or participate in any sports? yes no Frequency? _____
What kind? _____
- Do you perform any repetitive movement in your work, sports or hobby? yes no
If yes, describe _____
- Do you sit for long hours at a workstation, computer or driving? yes no
If yes, describe _____
- Are you experiencing tension, stiffness, discomfort or pain? yes no
If yes, describe _____
- Have you recently had an injury, surgery, or areas of inflammation? yes no
If yes, describe _____
- List any medications you are currently taking _____
- List any known allergies _____
- Do you follow a specific diet? yes no
If yes, describe _____
- Glasses of water per day? _____ Coffee? _____ Alcohol? _____
Do you or have you ever smoked? yes no # of yrs since quitting _____ # of yrs smoked _____
- I typically play music at low volume during sessions. Do you have any musical requests/suggestions?
Or do you prefer your sessions to be silent? _____

If there is anything else you think I should be aware of please note it here.

What are your goals for treatment?

Client Agreement

It is my choice to receive structural medicine session(s). I am aware of the benefits and risks of structural medicine and give my consent for these sessions. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that structural medicine is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature _____ Date _____