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The Art of Wellness, LLC
Intake Form

All information collected will be kept strictly confidential

Name

Gender/ Pronouns:

Cell Phone

Address

Email

Birthdate

Occupation

What is/are the issue/s that brought you to seek out The Art of Wellness? (Please list any past or current treatment you have had for these issues)

Please list relevant current medical status (pregnant, chronic conditions, mental health diagnoses, recent accidents, etc.) **and history** (trauma exposure, surgeries, fractures, past car accidents, concussions, sprained ankles, MRI's, X-rays, etc.):

Medical Guidelines: Has your doctor or other medical provider give you any guidance on things that you should or should not be doing to stay healthy?

Are you currently receiving health care? (if yes, where and from whom)

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Please list your current medications:

Stress: What is your current stress level (low, medium, or high), what are the major stressors (things that cause you stress), and what do you do to reduce or manage stress in your life?

Movement: What do you do for exercise or movement?

Nutrition: What is your nutrition like? Are there particular foods that you do or do not eat?

Sleep: How many hours of sleep do you generally get? What position do you sleep in (back/sides/belly)? When you wake do you generally feel well rested?

Hydration: How much water do you typically drink in a day? What other liquids do you drink?

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Smoking/ Alcohol/ Drugs: Do you smoke? If so, are you interested in quitting? How many drinks containing alcohol do you have per week? Any other recreational drug use?

Community: What degree of social support do you have in your life?

Goals: What are your goals for working with The Art of Wellness?

Is there anything else I should know about you or your health?

Change can be Hard: Are there any behaviors or lifestyle/wellness issues you struggle with that you would like my support to help implement?