1404 SE 25th Ave Suite #1 ◆ Portland, OR 97214 ◆ 802.281.2948
www.simplywell.info

CLIENT INTAKE FORM

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone_____ Email address _____

CONSENT OF SERVICES

I hereby authorize Marya Gendron, LMT, BCST to administer any services that she deems necessary in my case. I understand that Marya is not a doctor and therefore can't prescribe or treat. All information provided during health coaching sessions is educational and suggestive only, is not a replacement for medical advice, and should be brought to my primary care physician for consideration to evaluate to what extent, if any, her suggestions may be contraindicated with herbs/medications/or treatments already underway. I take full responsibility for my health and understand that Marya takes no responsibility for the outcome of such suggestions should I decide to try them. I also recognize that food is generally regarded as safe, and that most of her recommendations are limited to diet and lifestyle changes.

Patient/ Responsible Party signature

_____Date_____

CANCELLATION POLICY
Please give 24 hours notice if you cannot make your scheduled appointment. Cancellations without notification will be charged in full.

HEALTH GOALS:
What are your most important health goals? Please list in order of importance to you:

1._____

2._____

3._____

CHIEF CONCERN
Explain the main reason you are seeking bodywork or coaching:

_____

_____

_____

_____

IN YOUR HEART OF HEARTS, DO YOU BELIEVE IT IS POSSIBLE TO HEAL FROM THIS CONDITION?

_____

_____

ARE YOU CURRENTLY READY TO DO WHAT IT TAKES TO HEAL FROM IT (WHATEVER THAT MAY BE)? This could include but is not limited to: having the discipline to exert free will over food choices, instill new daily habits, examine emotional blocks around healing and ways that we sabotage the healing process, do deep detoxification, and/or take time off from work to rest, heal, or reset).

_____

_____

_____

_____

DURATION OF PRESENT CONDITION

_____

On a scale from 0 to 10 (most intense) please rate your discomfort
With your condition today:_____
When it first began:_____
At its worst:_____

When and how did it begin?

_____

_____

What do you believe caused/causes this condition?

_____

_____

What makes it better?

_____

_____

What makes it worse?

_____

On a scale of 0 - 10 (ten highest motivation), describe your motivation to better manage your condition _____ resolve your condition for good _____

How many hours per week would you be willing to devote to improving your health condition, above and beyond what you already do? ____

Is there anything that you know improves your condition, that you are not doing? If so, what is preventing you from following through with what you already know you need to do? (ie, what is the elephant in the room?)

_____

_____

_____

_____

MEDICATION you are presently taking (pharmaceuticals only):

_____

HISTORY OF PHARMACEUTICAL MEDICATION (Very important for health coaching clients - please give as much detail as possible, including duration of medication treatment - medications of important note include antibiotics, NSAID's, and any kind of opiate-based medication).

_____

_____

_____

MEDICINE you are presently taking (herbs, healing plants, homeopathy, essential oils, supplements) - and dosages/frequency:

_____

_____

HISTORY OF TRAUMA/INJURY
Please describe any significant accidents, injuries, trauma, or illnesses in the past

_____

_____

List any other hospitalizations or surgeries you have had. Include age, time and any problems since. PLEASE DETAIL ANY PHARMACEUTICAL MEDICATIONS GIVEN AT THAT TIME.

_____

_____

_____

FLUID INTAKE

How much water do you drink a day? _____

DIET

What percentage of your diet is made at home:_____

What percentage of your diet is from processed/prepackaged food:_____

What percentage of your diet is fresh (salads/fruit/smoothies):_____

Describe your intake of animal products in a given week: _____

_____

How many pieces of fruit do you normally eat in a week? _____

Anything else I should know about your diet/relationship to food? _____

_____

_____

_____

How many times per week do you consume:

Alcohol ____ coffee ____ wheat ____ cheese/yogurt/sour cream ____ chocolate ____

lunch meats/cured meats/bacon ____ Dried fruit ____ vinegar/soy sauce ____ chilli _____

cinnamon/nutmeg/clove____ pickles/sauerkraut _____ green drinks _____ candy _____

BODY CARE - Shampoo, lotion, makeup, face cream, deodorant
Do you use body products with synthetic chemicals, fragrances, or dyes? Yes ____ No ____

BIRTH CONTROL method (if female, if applicable) _____

MENSTRUATION: Is your cycle regular? (if applicable) _____

BLOOD PRESSURE: Circle one. High Normal Low

DIGESTION:
How many bowel movements do you have in a week? _____

How is your digestion? _____

_____

_____

Do any foods in particular cause you digestive upset or problems? _____

_____

SLEEP:
Describe the quality of your sleep _____

EXERCISE: Describe how and to what extent you get exercise

_____

CENTERING: Describe how you center yourself/what brings you joy
_____

_____

_____

_____

RESOURCES: Describe where/how you feel most supported in your life:

STRESS: Describe your current stressors:

Additional Info: Is there anything else you feel is important that I have not asked?