MIGRAINE RELIEF THROUGH MINERAL BALANCING

6 Coyote Canyon Dr. ◆ White Salmon, WA 98672 ◆ 802.281.2948
www.simplywellmigrainerelief.info

MIGRAINE RELIEF COACHING
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.

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).

_____

CONSTELLATION OF SYMPTOMS

Check all symptoms that you experience, conditions you have been diagnosed with, or factors you suspect play a role in your overall health status. For conditions that only applied in the past, but not currently, write "P." In the Other section, fill out any additional conditions or symptoms not included in the list, including any surgeries and what kind, and any genetic conditions you are aware of.

___ brain fog	___ headaches	___ migraines
___ food allergies	___ bloating	___ gallbladder attacks
___ gallstones	___ peripheral neuropathy	___ gas
___ heavy metal toxicity	___ shingles infection	___ epstein barr virus
___ amyloid beta plaque	___ hypothyroid	___ hyperthyroid
___ uterine fibroids	___ light sensitivity	___ cystic fibrosis
___ kidney stones	___ hormonal birth control	___ hysterectomy
___ copper IUD	___ PMS	___ Heavy Bleeding
___ easy bruising	___ low blood sugar	___ diabetes
___ scoliosis	___ kyphosis	___ candida overgrowth
___ brittle nails	___ nail fungus	___ white spots on nails
___ bulging veins	___ varicose veins	___ ringing or pain in ears
___ hemmerhoids	___ thin teeth enamel	___ dental abscess
___ cataracts	___ arthritis	___ neck and muscle tension
___ smoking	___ coffee addiction	___ addiction
___ insomnia	___ anxiety	___ depression
___ constipation	___ diarrhea	___ belching
___ traumatic childhood	___ other trauma	___ received many antibiotics
___ salycilate sensitivity	___ stroke	___ received many vaccines
___ sulfur sensitivity	___ hyper-flexibility	___ NSAID use

___ other _____

___ other _____

Check any of the following conditions for how/why/when your migraines manifest

___ menstruation	___ with aura	___ hemiplagic
___ chronic	___ at ovulation	___ digestive (food triggers)
___ chemical trigger	___ light trigger	___ sleep deprivation
___ sinus congestion	___ environmental allergies	___ electromagnetic pollution
___ emotional upset	___ medications	___ heat

___ other _____

___ other _____

DURATION OF PRESENT CONDITION

_____

When and how did it begin?

_____

_____

What do you believe primarily caused/causes this condition?

_____

_____

If you have migraines, how frequent are your migraines in a given month?

_____

_____

What makes it better?

_____

_____

_____

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

SLEEP: Describe your sleep. Do you fall asleep easily? Do you wake frequently? Do you dream? Do you wake with migraine? Do you wake with brain fog? When do you go to sleep?

_____

_____

_____

_____

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

How is your digestion? Please describe if you are constipated, have diarrhea, or even "loose" stool. _____

_____

_____

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

_____

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?

_____

_____

_____

_____

_____

_____

_____

_____