MIGRAINE RELIEF THROUGH MINERAL BALANCING

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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 coaching:
_____

_____

_____

_____

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
___ food allergies
___ gallstones
___ heavy metal toxicity
___ amyloid beta plaque
___ easy bruising
___ kidney stones
___ scoliosis
___ bulging veins
___ hemorrhoids
___ cataracts
___ smoking
___ headaches
___ bloating
___ peripheral neuropathy
___ shingles infection
___ hypothyroid
___ light sensitivity
___ low blood sugar
___ kyphosis
___ varicose veins
___ low appetite
___ arthritis
___ coffee addiction
___ migraines
___ gallbladder attacks
___ gas
___ epstein barr virus
___ hyperthyroid
___ cystic fibrosis
___ diabetes
___ candida overgrowth
___ ringing or pain in ears
___ panic attacks
___ neck and muscle tension
___ addiction

___ racing thoughts ___ anxiety ___ depression
___ constipation ___ diarrhea ___ belching
___ traumatic childhood ___ other trauma ___ received many antibiotics
___ salycilate sensitivity ___ stroke ___ received many vaccines
___ sulfur sensitivity ___ hyper-flexibility ___ NSAID use
___ fungal infections ___ candida ___ slow wound healing
___ lack of appetite ___ mood swings ___ natural copper highlights in hair
___ crave chocolate ___ dark/brown spots on skin ___ heavy metal poisoning

___ 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 _____

Sleep Quality - Check any that apply

___ fall asleep easily ___ wake in middle of night ___ trouble falling asleep
___ sleep apnea ___ poor sleep quality ___ wake refreshed
___ wake tired ___ night owl ___ oversleep but still tired
___ noise pollution ___ nightmares ___ can't remember dreams
___ medication for insomnia ___ partner snores ___ still breastfeeding at night
___ light pollution ___ migraines come on at night or early morning

other/comments

_____

_____

_____

Birth Control, Hormones, Pregnancy, Menopause (if female)
Mark a "P" for any that were true in the past, and check for any that are current.

___ IUD - copper
___ IUD - hormonal
___ uterine fibroids
___ irregular periods
___ depo provera
___ epidural
___ heavy bleeding
___ c-section surgery
___ spotting during periods
___ birth control pill
___ infertility
___ PMS
___ heavy periods
___ miscarriage
___ birth trauma
___ post-menopausal
___ tubal ligation
___ irregular periods
___ hormone replacement therapy
___ cystic fibrosis
___ spotting
___ breast tenderness
___ preterm birth of child
___ pitocin at birth
___ peri-menopausal
___ easy, light periods
___ hysterectomy
___ vaccines during pregnancy
___ medications during pregnancy
___ migraines gone in last trimester of pregnancy
___ nonhormonal birth control methods used

other _____

other _____

Signs and Symptoms in Nails
Mark a "P" for any that were true in the past, and check for any that are current.

___ white spots
___ no moons (lanula)
___ pale nailbeds
___ dents/pitting in nails
___ nail fungus
___ vertical ridges
___ small moons
___ healthy pink nailbeds
___ hangnails
___ splitting nails
___ horizontal ridges
___ big moons on fingers
___ brittle nails
___ discolored nails

other _____

other _____

Oral Health

___ thin teeth enamel
___ abscesses
___ dental abscess
___ gum disease
___ mercury fillings
___ fillings after 1980 (with copper)

_____

_____

_____

What do you believe primarily caused/causes your migraines?

_____

_____

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? ____

MEDICATION you are presently taking (pharmaceuticals only):

_____

HISTORY OF PHARMACEUTICAL MEDICATION (Very important - 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: _____

_____

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) _____

BLOOD PRESSURE: Circle one. High Normal Low

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

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?