

**INTEGRATIVE BODY THERAPY BIOFEEDBACK INTAKE INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Time of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

**SOC INDEX**

Number of organs removed		Personal Stress: relationships, work, life, purpose (1-10)	
Number of synthetic drugs currently		No. of sugar type products in a day (1-10)	
Number of time you smoke per day		No. of exercise sessions per week	
Number of steroid drugs used in the past year		Number of alcoholic drinks in a day (s	
Number of amalgams (silver) fillings in your mouth		Number of caffeine products per day (coffee, tea, soda, chocolate, energy bars)	
Number of street drugs used each month		Number of toxic exposures (radiation, asbestos, chemicals, pesticides, insecticides)	
Number of all known allergies		Number of major injuries (work related, sports, motor vehicle accidents)	
Number of unresolved mental/emotional factors (depression, anger, anxiety, panic attacks)		Number of major infections in the past (respiratory, sinus or other)	
I am responsible for my body (1-10)		Number of 8oz. glasses of water per day	
Amount of fat in diet		How many pounds overweight (1kilo=2.2lbs.)	

Describe any concerns and objectives (wellness goals) in seeking wellness services with Integrative Body Therapy:

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## *Health Questionnaire*

### ***Personal Information***

Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Billing Address (if different than above): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_  
Emergency Contact (name/number): \_\_\_\_\_

### ***Medical History***

What conditions have you been diagnosed with by a licensed professional (MD, ND, DC):  
\_\_\_\_\_  
\_\_\_\_\_

List all surgeries that you have ever had and approximately when they were done:  
\_\_\_\_\_  
\_\_\_\_\_

List what medications/herbs/supplements you take and what you are taking them for:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other types of services have you tried to resolve these concerns (allopathic, natural remedies, therapies and self treatments): \_\_\_\_\_

What types of medical, natural remedies, or self treatments have helped you the most: \_\_\_\_\_

What types of treatments have you had adverse reactions to: \_\_\_\_\_

List any known allergies or anaphylactic reactions that you've ever experienced: \_\_\_\_\_

List any diagnostics test(s) that have been taken recently including MRI, X-Ray, lab tests, cultures, etc.: \_\_\_\_\_

Have you had any injuries (work related, sports, motor vehicle). If yes, list the type and what year:  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant or have a pace maker? \_\_\_\_\_

Do you agree that you are ultimately responsible for your health condition? If your answer is no then explain why \_\_\_\_\_  
\_\_\_\_\_

I testify that the information that I have willingly provided is true to the best of my knowledge. In saying this I mean that I have not falsified any of the information in response to the questions that have been asked on this health questionnaire.

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Signature of Client

Date

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Print Name