Mind Body Freedom Therapy
4915 Monona Drive Ste 205
Monona, WI 53716

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Intake

Name:

Home Address:

Cell Telephone: Home Telephone:

Date of Birth: Age: Height/Weight: Sex: Pronouns:

Email Address:

Emergency Contact Name & Phone:

Your Occupation: Employer:

Reason for being seen:

Date of onset: Related to work? Auto accident? Legal case?

Explain:

Who can we thank for referring you?

Past Medical History

Physician: Date of last Physical Examination:

Physician's Clinic name and address:

Phone: Fax:

Check those that Apply:

Heart Attack, coronary bypass, cardiac surgery	Abnormal resting or stress ECG
Irregular heart beats	High Cholesterol
High/Low Blood Pressure	Diabetes
Blood Clots	Stroke/Aneurysm/Neurological
Pulmonary Disease	
Cancer	Pregnant
Ulcers	Hernia

Orthopedic problems or injuries (arthritis or any other bone, joint, or muscle problems)
Emotional / psychological disorders (including stress, anxiety, or sleep disturbances)

Physical Inactivity Chemical Dependency Smoking

Drinking Alcohol (include frequency, i.e. 1x daily, 3x weekly etc.)

Medications (please list) :

Allergies (please list) :

Please list past injuries & current/past diagnoses not listed above:

Please list past surgeries:

Current Health Status

Exercise & Strengthening or Stretching Program:

Water Intake/Elimination Patterns:

Nutrition Habits:

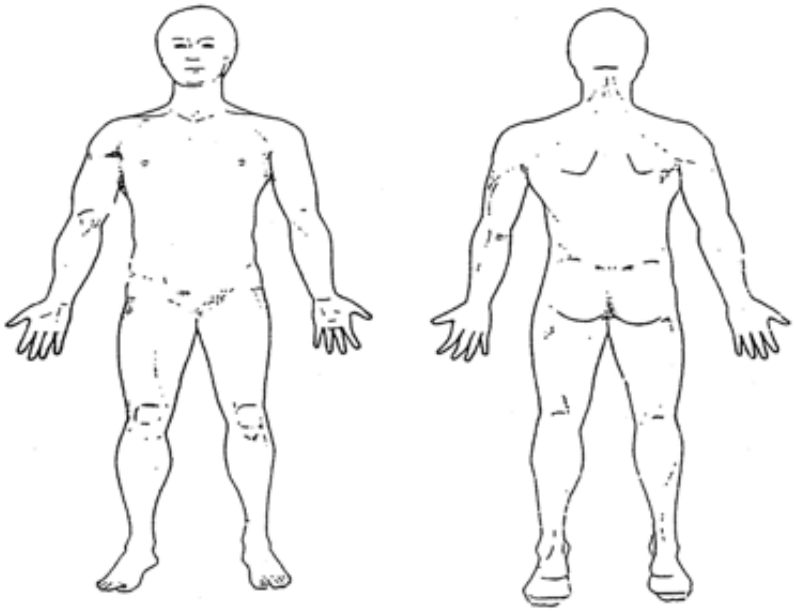
Sleep:

Connection with Others/Meaningful Socialization:

Sunshine Intake/Time in Nature:

Mindfulness/Ability to be in body vs. thinking/analyzing, stressed or busy:

Indicate where you feel pain, sensations, and symptoms below. Use pain scale 0 (no pain) to 10 (extreme pain) to indicate level of pain. (you can fill in the form at our in- person visit)



Please share your biggest goal you hope to achieve through therapy here:

Thank you.