thrive
wellness center
647 Wyoming Ave, Kingston, PA
570.283.0111

Client Initial Intake Form

Basic Information

Name:_____ Birthdate:_____ Gender: ☐Male ☐Female

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: *Home* (____)_____ *Cell* (____)_____ *Cell Provider* _____

Occupation:_____ How Would you like to be notified of appointments? Circle One: Text E-mail Both

Marital Status:_____ Number of Children:_____ Primary care Physician:_____

Email Address:_____ Best Way to Contact: ☐Mail ☐Phone ☐Email

Emergency Contact Information

Name:_____ Phone: (____)_____ Relationship:_____

Primary Complaint(s) *(Please list major symptoms and concerns)*:_____

_____

Secondary Complaint(s) _____

_____

Are you currently experiencing pain as a result of these symptoms? Yes No

If yes, please describe the pain: _____

When did the pain begin?_____

Past Medical History *(Please list any and all medical conditions, dates of occurrence & treatments. Include surgeries, accidents and other traumas. Etc.*

_____

_____

_____

Have you taken Antibiotics in the past six months? Yes No

Medical Information – *Please list all medications and supplements and their intended use*

Medications and Supplements	***Intended Use***	***Dose***	***Effectiveness***

Family History- *Please list any and all diseases / conditions that run in your family:*_____

_____

_____

Please Check All that Apply to you personally in the last 6 months:

- □ Abdominal Pain
- □ Addiction
- □ Alcohol Use – Freq: _____/wk
- □ Anxiousness
- □ Arthritis
- □ Blood Clots
- □ Breathing Difficulty
- □ Broken Bones/Fractures
- □ Chest Pain
- □ Chills / Fever
- □ Cold Hands / Feet
- □ Colitis
- □ Constipation
- □ Cramping in:
- □ Cystic Tumors
- □ Depression
- □ Diarrhea
- □ Difficulty Concentrating
- □ Dizziness
- □ Excessive PMS
- □ Fainting
- □ Fatigue
- □ Frequent Colds
- □ Genital Trouble
- □ Headaches
- □ Health Complications
- □ Heart Palpitations
- □ Heartburn
- □ Irritability
- □ Kidney Stones
- □ Low Blood Sugar
- □ Lower Back Pain
- □ Muscle Stiffness
- □ Nausea
- □ Neck Pain
- □ Non Rx Drug Use: Freq._____/wk
- □ Numbness
- □ Poor Appetite
- □ Poor Coordination
- □ Problems Eating
- □ Rectal Pain
- □ Relationship Changes
- □ Sinus Trouble
- □ Skin Eruptions
- □ Sore Throat / Cough
- □ Swollen Ankles
- □ Thoughts of Suicide
- □ Too Much / Too Little Sleep
- □ Ulcers
- □ Weakness in: _____
- □ Weight Gain
- □ Weight Loss
- □ Cancer
- □ Circulatory Problems
- □ Diabetes
- □ Epilepsy/Seizures
- □ Heart Disease
- □ High Blood Pressure
- □ Insulin Pump
- □ Joint Replacement
- □ Kidney Disease
- □ Limited Use of Limbs / Paralysis
- □ Liver Disease
- □ Lung Disease
- □ Metal Implants
- □ Migraine Headaches
- □ Muscle Stiffness
- □ Neurological Problems
- □ Osteoporosis/Osteopenia
- □ Pacemaker/Defibrillator
- □ Pregnancy
- □ Sciatic Pain
- □ Spinal Problems
- □ Stroke
- □ Thyroid Issues
  - □ Hyper
  - □ Hypo
- □ Tension in Neck and Shoulders

Have you ever consulted with any of the following:

☐ Iridologist	☐ Chiropractor	☐ Reflexologist	☐ Massage Therapist
☐ Medical Doctor	☐ Nutritionist	☐ Life / Wellness Coach	☐ Psychiatrist
☐ Physical Therapist	☐ Rolfer	☐ Acupuncturist	☐ Doctor of Naturopathy

Any Other Specialists

_____

How did you hear about us? Check all that apply:

- ☐ Friend:
  Who can we thank? _____
- ☐ Driving By
- ☐ Event _____
- ☐ Natural Awakenings
- ☐ Practitioner of Thrive: _____
- ☐ Facebook
- ☐ Internet Search / Thrive website
- ☐ Yelp
- ☐ Newspaper
- ☐ Television
- ☐ Radio
- ☐ From local shop/bulletin board
- ☐ Other_____

What topics are you most interested in learning more about?

Holistic Medicine	Detoxification	Massage
Nutrition	Aromatherapy	Juicing
Weight Loss	Homeopathy	Meditation
Supplements	Life Coaching	Iridology
Raw Foods	Reflexology	Holistic Certification Classes
Yoga	Psychotherapy	Qi Gong
Shiatsu	Traditional Chinese Medicine	Tai Chi

I verify that, to my knowledge, all of the information listed above is accurate.

Signature:_____ ***Date:***_____