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.*

_____

_____

List of Allergies/Sensitivities _____

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
- □ 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
- ☐ House of Nutrition
- ☐ Other_____

What topics are you most interested in learning more about?

Acupressure/Acupuncture TCM	Lyme Support	Reflexology
Aromatherapy/Essential Oils	Magnetic Therapy (PEMF)	Reiki
Detoxification	Massage	Sound Therapy
Holistic Medicine	Meditation	Supplements
Holistic Certification Classes	Metabolic Reboot	Tai Chi/Qi Gong
Homeopathy	Nutrition	Weight Loss
Hypnosis	Organic Skincare/Facials	Yoga
Iridology	Past Life Regression	
Life Coaching	Raw Foods/Juicing	

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

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