Male Confidential Client Intake Form

Name:____**Date of Initial Visit**____________________

Address____**State**_____________________**Zip**____________________

Home Phone______________________________**Work Phone**__________________**email**______________________________

Date of Birth_____________**Age**__________**Occupation**____

Marital/Relationship status______________________________**Referred by**____

Have you had massage/bodywork before?____________________ **What type?**_______________________________________

Reason For Visit

Primary reason for visit:____

When did your first notice it?________________________________**What brought it on?**_____________________________

Describe any stressors occurring at the time____

What activities provide relief?_______________________________**what makes it worse?**____________________________

Is this condition getting worse?___________________________**interfere with work**______**sleep**______ **recreation**_________

Medical History

Are you currently under the care of another health care provider(s)?_________________**Reason (s)**______________

____

Name(s) of Practitioner___________________________**Address:**____

Phone_____________________________________**email**____

Current Medications and /orSupplements/Remedies:____

Allergies: specify allergen and reaction:____

Surgical History (year and type) and/or Recent Procedures:____

____

Hospitalizations
____

____

Accidents or Traumas____

Falls/Injuries to Sacrum/head/tailbone (describe)____

Other:

Please review and check the following:

Headaches Type:	Past	Present	Pins and Needles in arms, legs Hands or feet	Past	Present
Asthma			Spinal Problems		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Loss of smell or Taste			Loss of Memory		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Muscular Tension: Location:		
Painful/Swollen Joints			Herniated/Bulging Discs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artifical/Missing limbs		

Other (not mentioned above)

Do you use Tobacco?______ Quantity_____/ppd Alcohol?______Quantitiy______ounces/ day
Marijuana?_______Quantity______Other:__________________Have you been under treatment for substance use?

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Digestion and Elimination

Typical Breakfast:____
_

Typical Lunch:____

Typical Dinner:____

Snacks:______________________________Water Intake(glasses/day)_________________Caffeine_________________

What is the worst item in your diet__________________What foods are your weakness__________________________

Are you subject to binge eating?_________________________What foods_______________________________________

Do you experience bloating/gas/burps after eating?__________What foods trigger this?__________________________

How often are your bowel movements?_____________________________Do your stools: sink______float_______

Constipation?_____________Blood in stool ?_________Mucus in stool?____________Pain when stooling?_________

Other concerns____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself?____

If possible, please describe the most negative emotion you experience____

When do you most often feel this emotion_________________Where are you?___________________________________

Do you pray to or have a spiritual practice____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself:

Faith_____________Hope_______________Charity________Generosity__________ Sense of Humor____________
Sense of Fun_____________Fear_________Grief________Other (describe briefly)_____________________________

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment______________________

Describe your exercise routine (type, frequency)____

What changes would you like to achieve in 6 months____________________One Year___________________________

MALE ~ REPRODUCTIVE HEALTH HISTORY

Check *and* **Describe** *those symptoms as* **applicable**

Headaches: Migraine_____Tension______Cluster_______Low back pain_____Sore heels______
Varicose Veins _____ Location____
Numbness in legs/feet

Family History of Prostate Disease:____Type________________Relationship____________________________

Family History of Cancer___________________Type________________Relationship_______________________

History of sexually transmitted disease____________When_________Type____________________________

Rate your interest in Sex:
High___________Moderate____________Low____________None_________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced a history of rape_______trauma_______incest__If so,-when______________________

Did you undergo counseling for this____

What was this like for you____

Urinary Symptoms (*circle those applicable*)

Painful urination **Bladder/Kidney infections**
Frequent Urination **Nocturnal Urination/ Frequency_________**
Changes in urinary stream (describe flow, stream, strength of stream)______________________________

When did you first notice these symptoms____

Are they getting better or worse____________Describe____

Erectile Function(*describe as indicated*)

Difficulty obtaining an erection **Difficulty maintaining an erection** **Painful ejaculation**

Is there a history of back
injury/trauma__________Describe:____

When did you first notice these symptoms____

Are they getting better or
worse_____________Describe____

Current Medications or Supplements:____

____

Results of PSA (prostate specific antigen) Test if known______________ Date done_____________________

Results of Sperm count (if applicable and known)______________________Date done_____________

AdditionalComments: