Holistic Women's Health Consultation
Confidential Intake Form

Pilar's
Wellness Collective + Apothecary

Date of Initial Visit_____

Name:_____

Address_____

City_____ State_____ Zip_____

Phone_____Alternate Phone_____

Email_____

Date of Birth_____ Age_____Occupation_____

Marital/Relationship status_____Referred by_____

Emergency Contact:

Name_____ Phone:_____

Relationship: _____

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

I understand that Pilar Chandler has been trained and is certified as a Holistic Health Practitioner and Ayurvedic Practitioner, Arvigo Practitioner, Herbalist, Massage Therapist, some of which do not currently have a licensing body in the state of California. California Senate Bill SB-577 allows for professionals to practice their healing art within their scope of practice.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I (name), _____
give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her. I understand this information may be used for the purpose of statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, date of birth.

(Cont. on back)

I agree to give notice of any change in my scheduled appointment time via phone, email or text **48 hours** before my appointment to avoid being charged in full for my scheduled time.

I agree that payment is to be received at the time of schedule or service. Cash or credit, debit, HSA or FSA card payments accepted. I understand that if I choose to pay with credit or debit card there is a 3% convenience fee added.

Client Signature: _____ Date: _____

Practitioner Signature_____Date:_____

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_____

Have you had massage/bodywork before?_____ What type?_____

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 /or Supplements/Remedies:_____

_____

Allergies: specify allergen and reaction:_____

Surgical History (year & type, include cosmetic & out-patient) and/or Medical Procedures:_____

_____

Hospitalizations: _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (from roller skating, snow boarding, horse back riding, etc.)_____

_____

Please list all scars on your body (surgical or non-surgical):_____

Other:

Please review and check the following:

Headaches Type:	Past Present	Numbness in feet or legs when standing	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	
Brain Fog _____ Slow Healing	_____	Hair Loss	

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues, or Reasons for**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastro-Instestinal Health

Describe your typical:

Breakfast:_____

Lunch:_____

Dinner:_____

What time do you take Breakfast:_____ Lunch:_____ 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?_____

Food Allergies / Sensitivites?_____Describe_____

How often are your bowel movements?_____Are your stools: sticky_____hard_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?_____

How often are you urinating? Daytime (average)_____ Number of times wake to urinate (average)_____

Any issues with bladder / urination (frequent urination, urgency, leakage, etc.)? _____

Check and describe all that apply:

	Describe Type	Daily	Weekly	Sometimes	Never
Wheat, gluten products					
Whole grains (quinoa, Rice, etc)					
Corn and corn products					
Nuts, seeds					
Legumes, beans					
Vegetables					
Fruits					
Eggs, dairy					
Poultry (chicken, turkey)					
Seafood					
Meat (beef, lamb, pork)					
Sugar, honey					
Deserts					
Processed foods					
Restaurant food					

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?_____

Describe the emotion when you are feeling most expanded_____

When and Where do you experience this emotion?_____

Describe the emotion when you are feeling the most contracted_____

When and Where do you experience this emotion?_____

Describe your Spiritual and/or Religious practice:_____

Do you feel satisfied with your life path?_____

Do you feel supported in your life's goals / dreams / ambitions? _____

On a scale of 1 – 10 (1 being lowest / worse, 10 being highest / greatest) Please rate these areas of relationship:

Co-workers / Community: _____ Friends: _____ Family:_____ Self:_____ Higher Power:_____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months:_____

One Year**:**_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day

Marijuana?_____Quantity_____Other:_____ Have you been under treatment for substance use?_____

Have you purchased a new car, new furniture or installed new carpets within the last 2 years? YES / NO

How would you describe your sleep experience?
Sound, normal duration_____ Light, interrupted_____ Not enough_____

Too heavy and/or too long_____ Difficulty falling asleep_____ Difficulty waking up_____

Awaken too early_____ Frequent nightmares_____

What time are you typically in bed? _____ What time are you up in the morning? _____

How do you generally feel when you wake in the morning?

Fresh and rested_____ A little tired_____ Moderately tired_____Very tired_____

How regularly do you follow your ideal routine (i.e., go to bed early, eat meals on time, exercise regularly)?

Very regularly_____ Somewhat regularly_____ Irregularly_____

How would you rate your usual energy level?

Very high_____ High_____ Moderate_____ Low_____ Very low_____

Female Reproductive Health

Methods of Contraception **(circle all that apply)** Pills Patch Diaphragm injection Condoms IUD Abstinence Rhythm Method

Vasectomy F.A.M. Menopause Other:_____Length of time using method_____

Last Pap smear_____Results _____

Are now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :_____

(IUI, IVF,etc)_____

Menstrual History Review and check as indicated:

Age of first Menses:_____What was this like for you?_____

Last Menstrual Period:_____Length of Bleed:_____Duration of Cycle:_____

Are you trying to Conceive? Yes_____No_____ Are you Pregnant? Yes____No____Unsure____

Painful Periods	**Past** **Present**	Irregular cycles Early Late	**Past** **Present**
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?		Sexually transmitted infections	

Do you do a breast self-exam regularly? Yes_____ No_____

Do you experience any of the following? Pain / Tenderness_____ Lumps_____ Nipple Discharge_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Do you have a history with rape____ trauma_____ incest_____Describe_____

Did you undergo counseling for this_____

Pregnancy History

Number of Pregnancies:_____Dates_____Miscarriage(s)_____Dates_____Termination(s)_____Dates:_____

Number of Births:_____ Dates:_____

Complications for any of the above, describe:_____

Premature Births?_____ Spotting During Pregnancy? _____Weak Newborns? _____Incompetent Cervix? _____

Describe your experience with:

Pregnancy (medications, complications, etc):_____

Labor (natural, induced, etc):_____

Birthing (vaginal, surgical, birth injuries, etc.)_____

Post Partum:_____

Breastfeeding:_____

How many weeks or months postpartum did your menstrual cycle return?_____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis PMS Menopausal issues

Cancer(type)_____Menstrual Problems _____ Other_____

Medications your mother took when she was pregnant with you (if any)_____

Your Birth Trauma (if known) _____

Menopause

Age symptoms began:_____Are they getting worse_____better_____same_____

Are you on/ or ever been on hormone replacement therapy?_____if so, how long_____

Name and dose_____

Reason for stopping_____

Age of Mother at menopause:_____Concerns/Experience_____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here: