

## A Simple Balance Intake Form

Name \_\_\_\_\_ Gender \_\_\_\_\_

Date of birth \_\_\_\_\_ Pronouns \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Phone# \_\_\_\_\_

Occupation \_\_\_\_\_

Life Interests/Hobbies \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Cell# \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

*Tensegrity Medicine uses Bowen, Lymphatic Drainage, Craniosacral, Neurovascular Release, Myoskeletal, Assessment, etc.*

Does a certain type of session appeal to you today, which one? \_\_\_\_\_

Describe what you are experiencing today? \_\_\_\_\_

How long has it been going on? \_\_\_\_\_

When the initial injury/pain occurred was there any stressful event happening for you?

What type of help have you gotten and how has your experience been?

What are your goals today and long term? \_\_\_\_\_

Please describe the following, with 1 being most negative and 5 being most positive.

Body sensations      1      2      3      4      5

Thought patterns    1      2      3      4      5

Sleep habits        1      2      3      4      5

Exercise habits     1      2      3      4      5

Appetite            1      2      3      4      5

Emotional state     1      2      3      4      5

Stress level         1      2      3      4      5

Please list one strength you feel you have and one weakness:

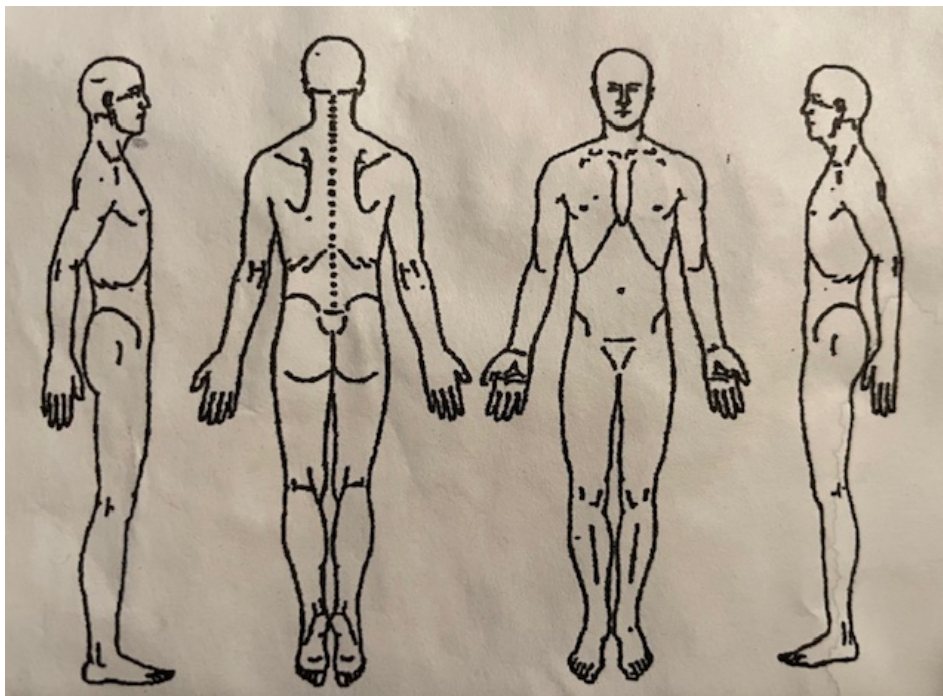
Strength \_\_\_\_\_ Weakness \_\_\_\_\_

**Current medications (or purpose for medications such as Cholesterol, Osteoporosis, etc)** \_\_\_\_\_

**Please check all that apply:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abdominal/digestive | <input type="checkbox"/> Ankle problem         | <input type="checkbox"/> Breast lump       | <input type="checkbox"/> Bursitis             |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Elbow pain        | <input type="checkbox"/> Fracture             |
| <input type="checkbox"/> Hamstring pain      | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Jaw/TMJ problems  | <input type="checkbox"/> Lung problem         |
| <input type="checkbox"/> Pelvic pain         | <input type="checkbox"/> Prostrate problem     | <input type="checkbox"/> Shin splint       | <input type="checkbox"/> Tinnitus             |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Back pain             | <input type="checkbox"/> Breast implants   | <input type="checkbox"/> Buttock pain         |
| <input type="checkbox"/> Colic (baby)        | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Fallen on tailbone   |
| <input type="checkbox"/> Hammer toe          | <input type="checkbox"/> Hip pain/replacement  | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Numbness             |
| <input type="checkbox"/> Plantar fasciitis   | <input type="checkbox"/> Rib pain/subluxation  | <input type="checkbox"/> Shoulder problem  | <input type="checkbox"/> Uterine/ovary issue  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Bedwetting (children) | <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Ear or eye            | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Gall bladder problem |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Incontinence/bladder  | <input type="checkbox"/> Knee problem      | <input type="checkbox"/> Migraines            |
| <input type="checkbox"/> PMS/menopause       | <input type="checkbox"/> Sacral pain           | <input type="checkbox"/> Sinus problems    | <input type="checkbox"/> Wrist or thumb pain  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bone spurs            | <input type="checkbox"/> Bunion.           | <input type="checkbox"/> Carpal tunnel        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Edema                 | <input type="checkbox"/> Fibroids          |   |
| <input type="checkbox"/> Heart problem       | <input type="checkbox"/> Infertility           | <input type="checkbox"/> Liver problem     |   |
| <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Sciatica              | <input type="checkbox"/> Sleep problems    |   |

**Circle the areas of concern and put the number from the pain scale below within the circle.**



**Right**

**Left/Right**

**Right/Left**

**Left**

**Pain intensity scale-**

- |   |   |
|---|---|
| (2) Mild pain (annoying, nagging)               | (8) Intense (cramping, dreadful, horrible)        |
| (4) Discomforting (troublesome, numbing)        | (10) Excruciating (tearing, crushing, unbearable) |
| (6) Distressing (miserable, agonizing, gnawing) |   |

\*\*I acknowledge that I have stated, to the best of my knowledge, all my known medical information or conditions. I acknowledge that the practitioner does not diagnose illness or disease, nor treat specific physical or mental disorders. I understand that working with an LMT is given for the purpose of stress reduction, relief from tension and energy within the bodymind system. I will inform my practitioner of any changes in my condition, and will contact my practitioner if I have any concerns.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Cancellation Policy:**

*48- hour advance notice is required for canceling an appointment except in case of illness, emergency or other unforeseeable circumstances. Clients who cancel appointments without 48-hour notice will be charged the full session rate. Thank you for your understanding.*

**The Tensegrity Medicine™ approach**

My approach to each session is “your body your rules.” If you need something different please communicate that to me; if you are uncomfortable in any way let me know. If you need clarification on anything we do in session, I am happy to walk you through it. I want to create an environment that helps you find your own answers in the way your body communicates to you. When you are able to ask for what you need, feel safe, comfortable, and informed, you can heal more thoroughly and for the long term.

We begin with physical assessments that illuminate where you experience areas of freedom and areas of restriction in the body-mind system. This relies on me as a practitioner being present and using my experience and my intuition. Based on this assessment, I select the procedure or modality that will be most beneficial at the moment.

In a healthy system, we can move in and out of compression and expansion with ease and glide in all our connections. Creating awareness of those connections shows us how we hold our tension or stress, and the influence of our belief systems, thought patterns, and responses to our environment, such as rest and digest, fight, flight, or freeze and collapse. Our system responds to how we talk to ourselves, how we are with others, and how we interpret the world around us. These responses create patterns in how we move and the structure of our physical being.

My goal is to help you create space within your body-mind system by identifying patterns and supporting you in finding the balance that is already within you. When we identify a restriction or block in our system, we want to: be curious about it, embrace it, be with it without needing to change it, reward it, accept it, learn from it, find out why it came and what its job is, encourage it if it wants something new, support it, integrate it, and allow the path to unfold!