The Center for

Mind-Body Medicine®

Science. Training. Community. Outreach.

Mind-Body Skills Group Intake Form

Date: _____ _____ **Birth Date:** _____

Name: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____
CITY STATE ZIP

Sex: ☐ **M** ☐ **F** ☐ **Single** ☐ **Married** ☐ **Partnered** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Home Phone: _____ **Work:** _____ **Cell:** _____

_____ **Occupation:** _____

_____

_____ **# of Children: Boys** _____ **Girls** _____

Who should we thank for referring you? _____
NAME OCCUPATION/RELATION

In case of emergency, whom should we contact? _____
NAME RELATION PHONE

_____

Are you currently under medical treatment? ☐ **Yes** ☐ **No**
Please Describe: _____

_____

_____

Do you see any other practitioners in the integrative area? ☐ **Yes** ☐ **No** **If yes, which area(s)?**

☐ Acupuncture	☐ Chiropractic	☐ Naturopathy	☐ Massage	☐ Healing Touch
☐ Homeopathy	☐ Chinese Medicine	☐ Nutrition	☐ Reiki	☐ Guided Imagery
☐ Hypnotherapy	☐ Biofeedback	☐ Hydrotherapy	☐ Aromatherapy	☐ Ayurveda
☐ Chelation	☐ Oxygen Therapy	☐ Prolotherapy	☐ Other Energy Work _____	
☐ Other Bodywork _____		☐ Other Practitioners _____		

Have you ever had any serious illnesses or operations? ☐ **Yes** ☐ **No**

Please Describe: _____

_____

_____

Are you currently taking any medications? ☐ **Yes** ☐ **No** (Continue list on back of sheet if needed.)

Name of Medication	How much do you take?	How did you come to take this?

Are you currently taking any nutritional supplements? ☐ **Yes** ☐ **No** (Continue list on back of sheet if needed.)

Name of Supplement	How much do you take?	How did you come to take this?