Jane Moody Healing Services

CONFIDENTIAL INTAKE FORM

WELCOME and thank you for taking time to fill this in. Anything you write will be held in strict confidence and treated with respect. This is a very thorough intake. Rest assured that this information is relevant to your treatment and valuable for your care. If you are *truly* uncomfortable with any question, please say so.

Date: _____

Name: _____ **Referred by**_____

Phone: (H) _____ **(W)** _____ **(C)**_____ **Heard of this treatment option through:**

Email: _____ _____

Address: _____

Marital Status: **Partnered** **Single** **Separated/Divorced** **Widowed**

Number and Ages of Children_____

Occupation: _____

Other Healthcare Providers: MD_____

ND_____ **DC**_____ **RMT**_____

Other_____

Permission to share information with health care providers, if it will help treatment ? **yes** **no**

YOUR PRIORITIES IN TREATMENT

1. _____

2. _____

3. _____

CURRENT HEALTH

What are your main health concerns at this time?

1) _____

2) _____

3) _____

Main PHYSICAL problems in order of severity (worst first). Make special note of chest pain, palpitations, high BP.

_____

_____

_____

_____

_____

Allergies (food, drugs, other):

_____

_____

SIGNIFICANT ILLNESSES / CONDITIONS (Please write date of diagnosis or event beside applicable conditions)

Arthritis	Diabetes	Asthma	Heart Disease	Epstein Barre
Blood Pressure	Cancer	Hepatitis	Kidney Disease	Depression
Seizures	HIV	Thyroid	Tuberculosis	MS

Other:_____

Surgeries (include date):

_____

Physical Trauma (accidents, falls etc, with dates):

_____

_____

Circle symptoms that have captured your attention or have recurred:

Candida	Strong thirst	Frequent urination	Chest pain	Nausea
Shortness of breath	dizziness	sudden unexplained abdominal swelling		significant fatigue

Other_____

LIFESTYLE

NUTRITION: Excellent Good Needs Help

Supplements:

_____

_____

Pharmaceutical medication:

_____

_____

Over-the-counter medication:

_____

CIGARETTES? Never Yes: amount/frequency_____ Quit: How long ago? _____

ALCOHOL/REC. DRUGS? Specify_____ **Frequency**_____ **Amount**_____

Quit: How long ago? _____

STRESS LEVELS: Low Moderate High

Stressors:

_____

_____

_____

How do you relax?

_____

_____

How often?_____

EMOTIONAL HISTORY

Circle any symptoms that have affected you recently and *note date*.

Stressed **Anxious** **Depressed** **Irritable** **Explosive** **Highly excitable**
Hearing Voices **Treated for emotional problems**

If you have considered or attempted suicide, please give details and dates:

_____

_____

Hospitalized for mental illness? **No**

Yes: details and dates_____

_____

Are you presently under psychiatric supervision? **No** **Yes:**

Physician:_____

CHILDHOOD RELATIONSHIP WITH MOTHER: **Good (warm, supportive, encouraging)**

Bad:Describe_____

_____

CHILDHOOD RELATIONSHIP WITH FATHER: **Good (warm, supportive, encouraging)**

Bad: Describe_____

_____

PARENTS RELATIONSHIP WITH EACH OTHER WHEN YOU WERE A CHILD: **Good**

Bad: Describe_____

_____

BIRTH ORDER & RELATIONSHIP w SIBLINGS:_____

_____

_____

SUPPORTIVE ADULTS IN YOUR LIFE AS A CHILD (anyone you counted on for security/encouragement, *if not at home*)

grandparent **aunt** **uncle** **friend's parent** **teacher** **neighbour**

Describe_____

YOUR *OWN* BIRTH & INFANCY EXPERIENCE, *IF UNUSUAL OR TRAUMATIC:* **forceps delivery** **long delivery**

premature **breech** **cord around neck** **c-section**
breast-fed **bottle-fed** **on demand** **on a schedule** **left to cry**

other:_____

SCHOOL

Relationship w Teachers_____

Other Children_____

RELIGIOUS / SPIRITUAL EXPERIENCE: **None** **Some** **Traditional Religious Attendance**

Other:_____

Belief in a Higher Power: **yes** **no** **Importance in your Life:** **very** **moderate** **not at all**

Details_____

CURRENT RELATIONSHIP: **Supportive/Loving** **Compatible but empty** **Abusive/unworkable**

Relevant Details:_____

_____

Is this a repetition from past experience?

_____

WHAT ARE THE STRENGTHS THAT YOU BRING TO YOUR LIFE?

_____

_____

_____

_____

_____

WHAT ARE YOU PASSIONATE ABOUT? (WHAT MAKES YOUR HEART SING?)

_____

_____

_____

_____

_____

THANK YOU VERY MUCH

PLEASE READ THE FOLLOWING AND SIGN AT THE BOT TOM

In all my years of practice, no one has ever experienced harm from my treatments. What follows is precautionary:

This form of treatment does not replace standard medical diagnosis and care. If you have disturbing symptoms, please seek medical advice as well.

I, (print your name)_____ understand the above. I also understand that emotional release can be part of treatment. Brief (48 hours or less) intensification of symptoms can be an indication of the body's healing process. In the rare event that these continue beyond 48 hours, please call me as broader investigation may be necessary.

*(**NB:** This does not apply to Heart Attack or Stroke symptoms. Regardless of whether you see me or not, educate yourself and seek immediate medical attention if you ever experience these symptoms. Signs of heart attack are different for men and women.)*

*** I have a standard 24 hour cancellation policy. ***

To protect everyone's valuable time, a 50%, *or full fee* needs to be charged for late cancellations and forgotten appointments, except in case of emergency or bad storms. Forgotten appointments or those cancelled within 24 hrs. of your scheduled time mean that someone misses out.

I have read and understood all of the above: SIGNATURE_____

I look forward to working with you. Please bring all pages to your appointment.