

INTAKE FORM



Name _____

Date _____

Phone _____

DOB ____/____/____

Occupation _____

Postcode _____

Email _____

Emergency name & contact _____

How did you hear about us? _____

Are you on any **medication** or supplements?

Yes No

If yes, which ones

Do you **exercise**?

Yes No

If yes, what do you do and how many times per week?

On a scale of 1-10, how **happy** are you? (*think about the last 2 weeks*)

1 = very unhappy;

10 = exceptionally happy

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how much **stress** is in your life

1 = LITTLE or no stress;

10 = exceptionally HIGH stress

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how much **energy** do you have? (*average day over the last 2 weeks*)

1 = very LOW energy;

10 = very HIGH energy

1 2 3 4 5 6 7 8 9 10

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Present State of Health (Current Symptoms)

Please explain and describe what is the main reason/s you are here?

What **symptoms** are you currently experiencing?

When did this start? and **what** do you think the cause is?

In relation to your current symptoms, what are they **preventing** you from doing?

Please describe if its **interfering** with aspects of your:


Work ?_____ Sleep ?_____ Routine ?_____ Other?_____








If those symptoms were to go away tomorrow, what would be **different about your life**?

Is there **anything else** significant in your history you think is helpful for us to know about in order to help you? If yes, please describe:

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If there are any **other relevant symptoms** in the list below, please circle:



Gateways	
AWAKEN 	<ul style="list-style-type: none"> Dizziness Fainting Loss of Memory Brain Fog Low Energy
PAUSE 	<ul style="list-style-type: none"> Neck Pain Stiff Neck Headaches Migraines Lights bother eyes Ears ring, Earaches Loss of smell/Taste Cold/Flu Hearing Problems Sleep disorders TMJ, Sinus problems
PASSION 	<ul style="list-style-type: none"> Neck, Shoulder or Arm Pain Thyroid Issues Food Sensitivities Tiredness after eating Numbness in Fingers Pins & Needles / Arms
CENTRE 	<ul style="list-style-type: none"> Chest Pain, Heartburn High or Low Blood Pressure Pain in Mid-Spine Breathing Issues, Asthma Gas, Burping Indigestion Kidney and Bladder problems
POWER 	<ul style="list-style-type: none"> Stomach/Digestive Problems Constipation/Diarrhea Lower Back Pain Disc problems Reproductive Issues Menstrual Pain
FOUNDATION 	<ul style="list-style-type: none"> Lower Back Pain Sciatica Hip Issues, Groin problems Pins & Needles / Legs Knee Pain
BASE 	<ul style="list-style-type: none"> Anxiety Nervous System Issues Neurological disorders Balance Loss Nervousness Numb toes Depression

About your health:

The human body is designed to be healthy. Throughout life, events occur which may impact or damage your health. Looking at your case history may uncover layers of impact or damage, especially to your nervous system. As we work together, we will begin to correct any layers of damage and assist you to recover your innate health potential.

The next pages help to find out what layers may have been damaged.

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Childhood & Teenage years

The teenage years can bring their own set of challenges.

What **significant events** did you experience during this time of your life?
Consider chemical, physical and emotional stressors.

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Impacts on your Whole Body Health (Adult years)

Damage can accumulate, possibly causing symptoms or bouts of illness.

Medications and other drugs

Do you **smoke**? Yes / No

If yes, or if you have a history of smoking, please **describe the habit**

- short period
- long period
- social smoker
- heavy smoker
- other

How **regularly**, if at all, do you consume **alcohol**?

If any, please describe your **relationship/history** with alcohol

Are you currently taking any **medications or recreational drugs**, how **frequently** and how long have you been taking it/them?

If any, please describe your **history** with **medications or recreational drugs**?

Do you believe your there has been any long term damage to you caused by

- Smoking
- Alcohol
- Medications/recreational drugs

Food and general diet

How would you rate your normal daily diet out of 10:

1 = very poor diet;

10 = exceptionally clean & healthy

1 2 3 4 5 6 7 8 9 10

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Accidents, Surgery, and Stressors

Have you been in any **accidents**?

Yes / No

If yes, when did it occur & were you injured?

Have you had **surgery** and/or **organs removed or replaced**?

Yes /No

If yes, please describe:

Do you have any problems with **sleep**? Eg sleep debt, wake up tired etc

Yes / No

What is your normal **sleeping posture** eg Side, Stomach or Back

Did you / do you have **occupational stress**?

Yes / No

If yes, please describe

Physical and / or **Mental stress**?

Yes /No

If yes, please describe

Do you have any other **injuries** not already mentioned?

Yes /No

If yes, please describe

Other current traumas, stresses or problems if not already mentioned?

Yes /No

If yes, please describe

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You have made a decision to have Spinal Flow treatment to improve an aspect of your health and well-being.

Are you able or willing to consider changes to your lifestyle in order to better assist healing, even if some of these changes are inconvenient?

Yes /No

Are there any changes you are already aware of that would positively impact your situation?

By signing this form, I agree and consent to the healing work.

I understand that with any healing process and work on my body, my symptoms may worsen before they get better.

I understand this care is designed to assist the body with healing by helping to remove stressors from the body. I understand that healing takes time and there is no quick immediate fix to my problem, and health is a process.

I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.






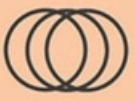

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Name _____

Signature of client _____ Date _____

7 GATEWAYS OF THE SPINE



GATEWAY	SPINAL LEVEL	NERVE SUPPLY	SYMPTOMS OF SPINAL BLOCKAGES	FEELS LIKE
AWAKEN 	Cranium	Head, Brain and Cranial Nerves	<ul style="list-style-type: none"> ● Low Energy ● Spaciness, Dizziness ● Memory Issues & Brain Fog 	You don't have enough life force or energy. You can feel disconnected and living life separate and alone.
PAUSE 	C1-C2, The Upper Cervical Spine	Neck, Eyes, Ears, Nose And Sinuses	<ul style="list-style-type: none"> ● Headaches, Migraines ● Colds, Flu, Earaches, Tinnitus ● TMJ, Sinus Problems ● Sleep Disorders, Snoring ● Learning Disorders 	Your head is about to explode and that your thoughts are not in alignment with your body. You are busy with thinking and stuck in the future.
PASSION 	C3-C7, The Lower Cervical Spine	Neck, Shoulders, Arm, Throat and Thyroid	<ul style="list-style-type: none"> ● Neck, Shoulder or Arm Pain ● Sore Throats, Thyroid Issues ● Swollen Glands ● Food Sensitivities ● Tiredness after Eating 	You need to swallow your thoughts and ideas. May feel as though no-one listens and you cannot speak your truth.
CENTRE 	T1-T12, The Thoracic Spine	Upper and Mid Back, Heart, Lungs, Gallbladder, Stomach, Pancreas, Spleen, Liver and Kidneys	<ul style="list-style-type: none"> ● Breathing Issues, Asthma ● Chest Pain, Heartburn ● High or Low Blood Pressure ● Gas, Burping ● Trouble with Fatty Foods, Indigestion ● Kidney and Bladder Problems 	Taking the weight of the world on your shoulders. Feels like you try to protect or hide your heart. Rarely prioritising yourself.
POWER 	L1 - L5	Low Back, Colon, Prostate, Uterus	<ul style="list-style-type: none"> ● Lower Back Pain ● Disc Problems ● Digestive and Reproductive Complaints 	Disempowered and don't have enough drive to get through life, feel withdrawn
FOUNDATION 	Sacrum	Pelvis, Groin, Hip, Leg, Knee, Ankle	<ul style="list-style-type: none"> ● Lower Back Pain, Sciatica ● Hip Issues, Groin Problems ● Knee Pain 	Being stuck in the past, can't move forward or make a decision. Overall feelings that you are unsupported.
BASE 	Coccyx	Tail Bone, Toes	<ul style="list-style-type: none"> ● Anxiety ● Depression ● Nervous System Issues ● Neurological Disorders 	Body is stuck in the fight: flight response and trying to survive rather than thrive. Can feel ungrounded, as though feet can't rest on the floor.