



Confidential Intake Form

CVT Services BodyTalk

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Today's Date: _____

Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Work Phone _____ Home phone _____ Cell Phone _____

Best place to leave a message for me is _____

E-mail Address: _____

Emergency Contact _____

Occupation _____ Referring/Primary Care Physician: _____

Check any of the following you are currently experiencing or have had in the past 5 years.

<input type="checkbox"/> headaches <input type="checkbox"/> migraines <input type="checkbox"/> sinus pain <input type="checkbox"/> sinusitis <input type="checkbox"/> sensitivity to temperature <input type="checkbox"/> sensitivity to weather <input type="checkbox"/> lowered immune function <input type="checkbox"/> swollen glands <input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> muscle or skin twitching <input type="checkbox"/> muscle pain <input type="checkbox"/> tendonitis <input type="checkbox"/> sprains/strains <input type="checkbox"/> joint pain <input type="checkbox"/> arthritis <input type="checkbox"/> back pain <input type="checkbox"/> scoliosis <input type="checkbox"/> herniated or bulging disk(s) <input type="checkbox"/> sciatica/nerve impingement <input type="checkbox"/> high cholesterol <input type="checkbox"/> high/low blood pressure <input type="checkbox"/> heart pain/palpitations <input type="checkbox"/> heart attack; when _____ <input type="checkbox"/> poor circulation <input type="checkbox"/> swelling <input type="checkbox"/> varicose veins <input type="checkbox"/> blood clots	<input type="checkbox"/> dizziness or fainting <input type="checkbox"/> clumsiness/loss of balance <input type="checkbox"/> numbness/tingling <input type="checkbox"/> epilepsy <input type="checkbox"/> seizures <input type="checkbox"/> fatigue <input type="checkbox"/> CFS <input type="checkbox"/> Epstein Barr <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> cancer/tumors <input type="checkbox"/> nervous stomach/ulcers <input type="checkbox"/> indigestion/acid reflux <input type="checkbox"/> painful gas/bloating <input type="checkbox"/> digestion disruptions <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> painful urination <input type="checkbox"/> urgency/incontinence <input type="checkbox"/> excessive or no thirst <input type="checkbox"/> dry mouth <input type="checkbox"/> liver impairment <input type="checkbox"/> hepatitis <input type="checkbox"/> shingles <input type="checkbox"/> herpes	<input type="checkbox"/> kidney disorders/stones <input type="checkbox"/> gallbladder disorder <input type="checkbox"/> depression <input type="checkbox"/> anxiety/panic attacks <input type="checkbox"/> mood swings/volatility <input type="checkbox"/> rage/uncontrollable anger <input type="checkbox"/> hyperactivity <input type="checkbox"/> obsessive/compulsive behaviors <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Autism/Aspergers <input type="checkbox"/> excessive perspiration <input type="checkbox"/> loss of memory <input type="checkbox"/> sleep difficulties <input type="checkbox"/> night sweats <input type="checkbox"/> skin breakouts <input type="checkbox"/> skin rashes/psoriasis <input type="checkbox"/> obesity/weight loss <input type="checkbox"/> thyroid disorders <input type="checkbox"/> diabetes <input type="checkbox"/> eye pain	<input type="checkbox"/> vision changes <input type="checkbox"/> loss of smell <input type="checkbox"/> nose bleeds <input type="checkbox"/> loss of taste <input type="checkbox"/> dental conditions <input type="checkbox"/> jaw pain/teeth grinding <input type="checkbox"/> loss of hearing/ringing Women only: Pregnant (y/n)____ desire pregnancy (y/n)____ birth control method _____ painful menstruation____ irregular periods____ menopausal____ endometriosis____ breast pain/lumps____ painful intercourse____ ovarian/uterine cysts____ infertility____ Men only: Genital pain____ erectile dysfunction____ prostate issues____
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List all medications/herbs/vitamins: _____

List physical activities/exercise you participate in regularly _____

Describe the events of recent injuries or accidents: _____

List previous (past 5 years) major injuries/surgeries: _____

List other treatments you are receiving (acupuncture, physical therapy, chiropractic, naturopathic):

What seems to aggravate your condition(s) the most? _____

What seems to help the most? _____

What is your main activity at work? On phone _____ Sitting _____ Computer work _____

Driving car _____ Walking _____ Physical Labor _____ Other _____

What do you do to relieve stress _____

Please wait to fill out this portion with the Practitioner. We will rate the following areas on a scale of 1-10
(with #1 being the best and #10 being the worst)

Level of stress: _____ Diet: _____ Food Relationship: _____ Alcohol/Rec Drugs: _____

Physical health: _____ Emotional health: _____ Sexual/Sensual life: ___/___ Social life: _____

Money Rel/Prosperity consc: _____ Family life Or/Nuclear: ___/___ Spiritual health: _____

I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the appointment fee.

Signature _____ Date _____

Practitioner Comments _____

