

Salus Healing Center
Client Intake Form

Pain and poor health can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form.

Name _____ Today's date _____

I want to receive mailings and offers just for clients of Salus Healing Center: Yes / No

Email address _____

Address _____

City, State _____ Zip Code _____

Home number _____ Work number _____

Occupation _____ Cell number _____

Gender M / F _____ Number of children _____ Ages: _____

Your Date of birth _____ Age _____

In case of emergency – Contact Person: _____ Phone Number: _____

Family Doctor _____

Referred by/how did you hear about us? _____

Have you had professional alternative health care before? Y / N

What type of care was it? _____

By whom? _____ When? _____

Do you have reason to believe you may be pregnant? Y / N Due date: _____

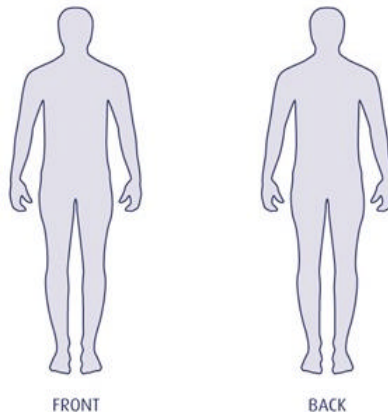
Describe any exercise you do, including frequency and duration. _____

What is your main physical activity at work? _____

What prompted you to make this appointment?

What are your health goals, and how do you see us helping you to accomplish them?

Mark any affected area(s) or painful areas on the figures shown here:



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Have you had any falls, accidents or injuries? Y/N If yes, please explain and give the month and year of the incident(s) _____

List any diseases you're your doctor(s) have diagnosed you as having.

Have you ever had surgery? Y/N If yes, please give type and date (month and year) _____

What flavors do you crave? (circle all that apply):

Sweet Salty Sour Bitter Astringent Acrid Pungent

Please write down everything you have eaten and drunk in the last twenty-four hours.

Is this a typical day? If not, why not? Please describe:

How would you describe your relationship with food? _____

Fluids

Drink:	Coffee	Water	Alcohol	Soda	Tea	Herb Tea
# per day:						
Type:						

Do you prefer warm, tepid, or cold drinks? _____

Do you engage in binge drinking? If, yes, how often. _____

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Sleep Cycle

Do you have a hard time falling asleep? _____

Do you wake during the night? If yes, please estimate the time you most often wake up.

Do you dream? _____

Do you have nightmares? _____

Do you have trouble achieving deep sleep? _____

List drugs, herbs, or supplements taken recently, please include type and dosage:

List drugs, herbs, or supplements taken in the past, please include type and dosage:

How often do you experience headaches? _____

Please provide a brief medical history for your parents, siblings, and grandparents, if blood relatives:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments:
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Salus Healing Center 1309½ 4th St SE Minneapolis MN 55414 (612) 379-7669

Our herbalist has studied under a number of herbalists in Minnesota and other parts of the country as well as participating in conferences on alternative healing.

Our Reiki practitioner is a third degree Usui Reiki Master.

Our massage therapist is certified by the American Oriental Bodyworker Therapists Association.

All other practitioners at the Salus Healing Center are licensed by the state of Minnesota. Minnesota does not license herbalists, massage therapists, or Reiki practitioners at this time.

The state of Minnesota has not adopted any educational and training standards for unlicensed complimentary and alternative health care practitioners. This statement of credentials is for informational purposes only.

Under Minnesota law, an unlicensed complimentary and alternative health care practitioner may not provide medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

If you have any concerns about our unlicensed practitioners, you may file a complaint with the following office.

Office of Complementary and Alternative Practice (OCAP)
Minnesota Department of Health
P.O. Box 64975, Suite 400
Metro Square Building
St. Paul, MN 55164
The number for general info at DOH is 651-215-5800

Understand that this is a professional setting, free of innuendos, advances, or abuse of verbal, physical, or sexual nature. Please let the practitioner or a staff member know if you are uncomfortable at any time.

Your records are private and will be kept private. Only you and your practitioner have access to your records. Your information *with all identifying information removed* may be shared for educational purposes.

Individual practitioner's fees are in their brochures, payment is due at the time of service, cash, check and credit card accepted. Terms can be negotiated with individual practitioners as needed prior to appointment only. Reasonable notice will be given in the event of a change in charges for services.

Patient is responsible for payment of services rendered. A charge will be applied to credit card accounts for missed appointments. Cancellations must be made 24 hours prior to the appointment, by telephone. **I understand that I may be charged for missed appointments.**

Name (Please Print): _____

Signature: _____ Date: _____