Client Last Name: _____

Idyllwild Intake

Name:_____

Email: _____

Address: _____

Phone Number: _____
Is it ok to leave you messages at this number?
___ Yes
___ No

Date of Birth: _____

General Health

What is your primary concern? (Please tell us body region and a bit about your symptoms):

_____

_____

_____

When did this begin? _____

Do you have any additional concerns? (Please tell us body region and a bit about your symptoms):

_____

_____

_____

How do these concerns impact your quality of life? (Please tell us if you are limited from doing anything specific):

_____

_____

Client Last Name: _____

Have you seen anyone else for this? If yes, who? _____

_____

Describe any treatment you have received and the results?

_____

_____

_____

What aggravates the condition? _____

What improves this condition? _____

What do you believe is causing your most important health concern? _____

_____

_____

_____

How would you describe your general state of health? (Check one):
___ Excellent
___ Good
___ Fair
___ Poor

Describe any notable events in your past medical history - please list things that you don't believe are related:

_____

_____

_____

_____

Client Last Name: _____

Do you have any allergies? If so, what?

_____

Health Conditions: please check for any conditions you have experienced or are experiencing:

___ High blood pressure
___ Heart attack
___ Low blood pressure
___ Stroke / CVA
___ Pacemaker / similar device
___ Chronic Congestive Heart Failure
___ Phlebitis / Vericose Veins
___ None of the above
___ Chronic Cough
___ Asthma
___ Shortness of breath
___ Emphysema
___ Bronchitis
___ Hepatitis
___ HIV / Aids
___ Skin Conditions
___ TB

___ None of the above
___ Osteoporosis / Osteopenia
___ Arthritis
___ Diabetes
___ Epilepsy
___ Cancer
___ History of headaches
___ Dizziness / double vision
___ History of migraines / new onset
___ Hearing loss / ear conditions
___ Vision loss / changes
___ None of the above
___ Allergies / hypersensitivities
___ Mental Health Diagnosis
___ Digestive conditions
___ Organ dysfunction

___ None of the above
___ Other: _____

Please list any surgical procedures:

_____

Habits and lifestyle (please check all that apply):

___ Smoke
___ Drink Alcohol
___ Soda

Do you sleep well? How many hours on average? _____
Do you drink water throughout the day?
_____
What are your exercise habits?
_____

Client Last Name: _____

Current emotional health (how stressed are you from 1-10 - 1 being no stress and 10 being extremely stressed):

_____

Medications and Supplements:

_____

Pelvic Health

Are you currently pregnant? If yes, please list due date:

_____

Number of prior pregnancies: _____

Have you experienced changes in your continence? If so, please describe:

_____

_____

_____

Do you have a past history of trauma?
___ Yes
___ No

Client Last Name: _____

Consent to Treat and Communication

I understand that Whitney Shepperd, OTR/L will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and payment. I give Whitney Shepperd permission to communicate via text, email, and leave voicemails as necessary for communication:

___ I agree

I give my consent to Whitney Shepperd to furnish care and treatment that is considered necessary and proper in the treatment of my physical condition. I understand that I will maintain bodily autonomy at all times and have full control over further treatments that will be discussed with my therapist:

___ I agree

Cancellation Policy

Important Financial Information

In order to maintain the highest quality of service as well as to continue progressing with the established plan to help reach your goals we ask that you show us consideration with the following:

- Cancellation less than 24 hours or a failure to arrive at your scheduled appointment will be billed at the cost of a standard session ($125.00). Please Call Whitney for all cancellations and appointment rescheduling. 413-217-4024
- Payment Schedule: I understand that fees for services are due at the end of each session unless written agreement is made with Whitney Shepperd.
- Payment Options: Check/Cash/Venmo.
- Insurance Claims/Billing: I understand that the full fee for each session is due and payable at the time of service unless agreed upon with my therapist.
- Returned Checks: I agree to pay $40 for checks returned due to non-sufficient funds.
- Late Starting Appointments: I understand that if I am late, the session will conclude at the scheduled time to show consideration for other clients scheduled following.

Do you agree to the above statements?

___ I agree

Patient/Parent/Guardian Signature:_____

Date:_____