Sacred Spaces Holistic Centre
Holistic Intake Screening & Self-Evaluation
Frank + Donnia Denig, Holistic Practitioners

sacred spaces
HOLISTIC CENTRE

Our Policies Effective immediately May 2020

Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, we understand and request for you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for cancellations.

Please note, we are temporarily limiting the number of daily appointments. The health and safety of our clients and staff is very important to us. For this reason, walk-in appointments will not be accepted and clients who are not currently receiving a service will be asked to step out in order to control the number of people within the space. If you are experiencing a fever, cough, or sore throat, please reschedule your appointment for when you are no longer symptomatic. If you have been to a COVID-19-impacted area or have been in close contact with a person infected with COVID-19, we ask that you please reschedule your appointment for at least 14 days past the date of contact.

We are requesting that clients wear face coverings when they arrive for their appointments. You will receive a new mask with a filter during your session.

Populations that are especially vulnerable to COVID-19 may have stricter and extended shelter-in-place recommendations. This includes clients who are 65 years and older, and those with conditions such as heart disease, lung disease, diabetes, and suppressed immune systems.

In accordance with extended shelter-in-place recommendations to protect our more vulnerable populations, we are not working with patients with compromised immune systems, clients aged 65 or above, or patients in other elevated at-risk categories at this time.

Please sign and return with your intake form.
I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner.

Date _____ Signature _____

Policy is subject to change rev. MAY 2020
Sacred Spaces Holistic Centre 105 Mechanic Street Bradford PA 16701 814-596-1004

The Holistic Body - Mind, Body & Spirit Health History

Amid the ongoing uncertainty of COVID-19, we have modified our policies. See our policy sheet before filling out this intake. If you have been sick for any reason in the last 3 months, we require a doctor's release.

Today's Date: _____

Name:_____ Date of Birth: _____ Age:_____ Gender: □ M □ F

Home Address:_____

City:_____ State:_____ Zip:_____

Email:_____

If under 18, person responsible for your account: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Emergency Contact: Name/Relation: _____ Phone: _____

Marital Status: _____single _____married _____divorced _____widowed _____with a significant other

Are you a caregiver for dependents? Yes No If yes, how many children?_____ How many adults_____

Occupation/yrs: _____ Retired/yrs: _____

PHYSICIANS / PROVIDERS INSURANCE Provider _____
Primary Care Physician (PCP)

_____

Please provide the name and title of all other practitioner(s), the condition(s) being treated and the length of time you have been receiving this treatment. Please include any acupuncturists, chiropractors, massage therapists or Naturopaths or homeopaths.
Practitioner Name Condition/s Dates of Treatment Phone#

_____

_____

REASON/EXPECTATION FOR TODAY'S VISIT:

_____

CURRENT HEALTH CONCERNS

Are you currently, today being treated for a cold, cough or flu with Antibiotics? □ Y □N
If yes, we cannot provide bodywork until the antibiotics have been eliminated from the body. This is to avoid the spread of your current illness within your own body as well as passing it to the practitioner.
Please list your top 3 health concerns in order of priority.

1. _____

2. _____

3. _____

SPECIAL COVID19 HEALTH QUESTIONS

Have you had a fever in the last 24 hours of 100˚F or above? _____ Temp today _____

Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
_____

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? _____

SPECIAL COVID19 INFORMED CONSENT:

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MEDICAL CONDITIONS: PLEASE CHECK ALL THAT APPLY TO YOU:

- □ Alcoholism/substance abuse
- □ Arthritis/Joint Disease
- □ Blood Clot/Phlebitis
- □ Cancer (Type): _____
- □ Deep Vein Thrombosis
- □ Diabetes
- □ Digestive (Ulcertive Colitis, Crohns, etc.)
- □ Fibromyalgia
- □ Frequent Infections
- □ Allergies/Sensitivities (Scent, medicines, skin, food, seasonal)
- □ Heart Attack, Heart Disease, Heart Failure
- □ High Blood Pressure
- □ High Cholesterol
- □ Liver Disease, Hepatitis
- □ Lung Disease (Asthma, COPD)
- □ Mental Trouble/ Depression/Anxiety, etc.
- □ Thyroid Disease
- □ Urinary Difficulties (incontinence, infections, prostate etc.)
- □ Other _____

MEDICATIONS
Please list any and all medications you are currently taking

_____

_____

_____

_____

SUPPLEMENTS
Please list any and all supplements you are currently taking

_____

_____

_____

_____

WOMEN'S HEALTH

Age at First Menses____ Number of Pregnancies____ Birth Control? _____

Duration of Menses_____ Number of Births_____ What type? _____

Number of Miscarriages____ Vaginal Discharge or sores_____ Number of Abortions_____

Fertility Problems_____ Breast Lumps_____ Difficult Births_____

Perimenopausal? Yes No Year Menopause _____

First Date of Last Menstrual Cycle _____/_____/_____

Date of Last Pap Smear _____/ _____/ _____

Did you have any abnormal findings in your last tests or anytime in the past? Please give details:

MEN'S HEALTH

What date was your last prostate exam? _____ PSA Test?_____ Colonoscopy? _____

Do you have: Prostate problems_____ Testicular cancer_____

Vasectomy_____ Sexual dysfunction or impotence_____

CHECK IF YOU HAVE EXPERIENCED *ANY* OF THESE SYMPTOMS *(in the last year)*

GENERAL

- □ Fevers
- □ Frequent Colds
- □ Tremors
- □ Change in Appetite
- □ Chills
- □ Seizures
- □ Fatigue
- □ Night Sweats
- □ Poor Sleep/ Insomnia
- □ Day Sweating
- □ Headaches
- □ Bleeding or Bruising
- □ Emotional Changes

CARDIOVASCULAR

- □ Dizziness
- □ Swelling of Hands
- □ Irregular heartbeat
- □ Fainting
- □ Difficulty in Breathing
- □ Palpitations
- □ Low blood pressure
- □ Cold Sweats
- □ Chest pain
- □ Swelling of Feet
- □ Phlebitis
- □ Other

RESPIRATORY

- □ Cough
- □ Pain w/ Deep Breaths
- □ Difficulty Breathing
- □ Bronchitis
- □ Shortness of Breath
- □ Easily Winded w/ exertion or when laying down
- □ Coughing Blood
- □ Production of phlegm

GASTROINTESTINAL

- □ Nausea
- □ Abdominal Pain/Cramps
- □ Vomiting
- □ Constipation
- □ Indigestion / reflux
- □ Diarrhea
- □ Blood in Stool
- □ Hernia
- □ Hemorrhoids

GENITOURINARY

- □ Pain on Urination
- □ Decrease in Urine
- □ Kidney stones
- □ Urgent Urination
- □ Blood in Urine
- □ Waking up to Urinate. How often _____
- □ Frequent Urination
- □ Unable to Hold Urine

NEUROPSYCHOLOGICAL

- □ Areas of Numbness
- □ Anxiety
- □ Lack of Coordination
- □ Poor Memory
- □ Dizziness
- □ Loss of Balance
- □ Easily Angered
- □ Headaches
- □ Fainting
- □ Depression
- □ Migraines
- □ Mania
- □ Susceptible to Stress

MUSCULOSKELETAL

- □ Muscular Weakness
- □ Recent Sprains
- □ Muscle Cramps
- □ Spasms
- □ Joint Pain
- □ Injuries or Falls
- □ Localized Weakness
- □ General Aches
- □ Joint Instability
- □ Scoliosis, Kyphosis or Lordosis

SENSES – any issues?

- □ Sight _____
- □ Taste _____
- □ Sound _____
- □ Smell _____
- □ Touch _____

STATEMENTS – Please check any of these that are true

- □ I feel connected to my body
- □ I am sensual and joyful
- □ I am authentic + courageous
- □ I completely accept myself
- □ I can express myself easily
- □ I am intuitive + creative
- □ I listen, trust and honor the divine within me

HABITS & LIFESTYLE

SELF-CARE PRACTICES

What are your DAILY current self-care practices for body, mind and spirit? Check all that apply.

- □ Wake early
- □ Prayer upon rising
- □ Clean face, mouth, eyes
- □ Drink water
- □ Elimination
- □ Scrape your tongue
- □ Clean your teeth
- □ Gargling
- □ Nasal clearing
- □ Abyhanga – warm oil application on entire body
- □ Bathing
- □ Dressing
- □ Perfume
- □ Exercise
- □ Breathing
- □ Yoga
- □ Meditation
- □ Eating
- Other

LIFESTYLE + HABITS

Emotional Stress Scale (*Please circle)* 1 2 3 4 5 6 7 8 9 10

Do you smoke?_____ If yes, what? _____

How much per day? _____ Since when?_____

How many attempts have you made at quitting smoking?_____

Do you drink alcohol? _____ If yes, what? _____

How much? _____ Since when?_____

How do you express gratitude in life? How often? _____

Do you exercise regularly? _____ If yes, describe what you do: _____

How often do you get out in nature? _____

NUTRITION + DIGESTION

What are your greatest nutrition concerns?

_____

What is your biggest nutrition challenges? Time _____ Expense _____ Too tired? ____ Don't cook? _____

How many meals do you generally eat per day? _____ Do you skip meals? _____

Do you eat meals at regular times daily? Y N

How many servings of fruit do you consume per day? _____

How many servings of vegetables do you consume per day?_____

Are you currently on a special diet?_____ What foods do you avoid?_____

Vegetarian or Gluten-free?_____ What food(s) do you crave? _____

Do you have symptoms after eating, ex bloating, hives, heartburn? _____

Consume fast food? What and how often? _____

What percentage of your meals are home cooked with fresh ingredients? _____

What percentage of your meals are pre-packaged (mac/cheese, soup, canned foods) ? _____

Coffee Drinker? Yes No If yes, how much/day?_____ Herbal Tea? Yes No If yes, how much/day?_____

Soda drinker? Regular Diet None *(Please circle one)* If yes, how much/often?_____

Eating habits regular? Yes No My appetite: □ Regularly hungry □ Erratic Hunger □ No appetite

Do you eat more when under stress or feeling depressed? Yes No

Do you experience sudden drops in energy? Yes No If yes, when? _____

What was your weight one year ago?_____

What is the most you have ever weighed?_____ When?_____

ELIMINATION

How often do you have a full bowel movement? _____

BM consistency

- □ Soft and well formed (banana shaped)
- □ Difficulty to pass
- □ Often Float
- □ Diarrhea
- □ Small and hard
- □ thin and narrow
- □ loose but not watery
- □ Constipated often

ESSENTIAL OIL USE

Do you use essential oils? Y N Which oils (*not brand*) and for what? _____

How do you use them? □ Inhalation □ Topically □ Ingestion

Are you familiar with safety protocols? Y N

SLEEP / RELAXATION

What is your nighttime routine, if anything, before you go to bed?

_____

How many hours do you usually sleep per night? _____ What time do you go to bed? _____

Do you wake feeling refreshed? _____

MENTAL HEALTH STATUS

Do you currently experience any of the following in relation to your mind:

- □ Dull
- □ Scattered
- □ Easily Irritated
- □ Bored
- □ Fullfilled/Content
- □ Focused
- □ Lethargic/Slow
- □ Wandering

Do you have any of the following emotions/experiences

- □ Connection to higher power (God, faith, religion, spirituality, universe)
- □ Hobbies you enjoy
- □ Passion for life
- □ Strong faith
- □ Waivering faith
- □ Faith is absent
- □ Do you spend time alone?

How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

_____

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

_____

At what point in your life did you feel best? Why? _____

_____

OTHER

What are your health goals/aspirations?

_____

Do you have family and friends who will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

_____

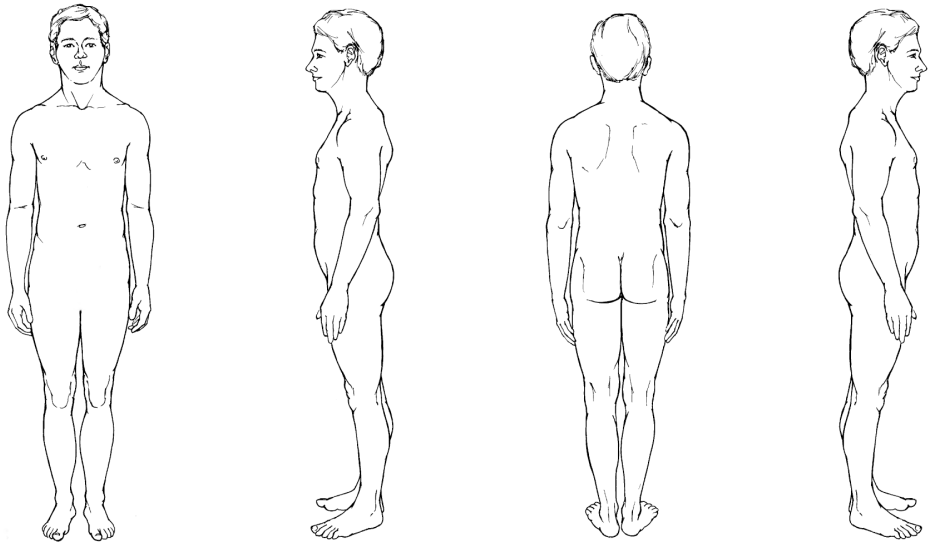
Who in your family or on your health care team will be *most supportive* of you making dietary change?

_____

Though it may seem odd, please consider why you might want to achieve that for yourself:

_____

On the below diagram, please mark with a circle, or "x" where you are experiencing pain or discomfort



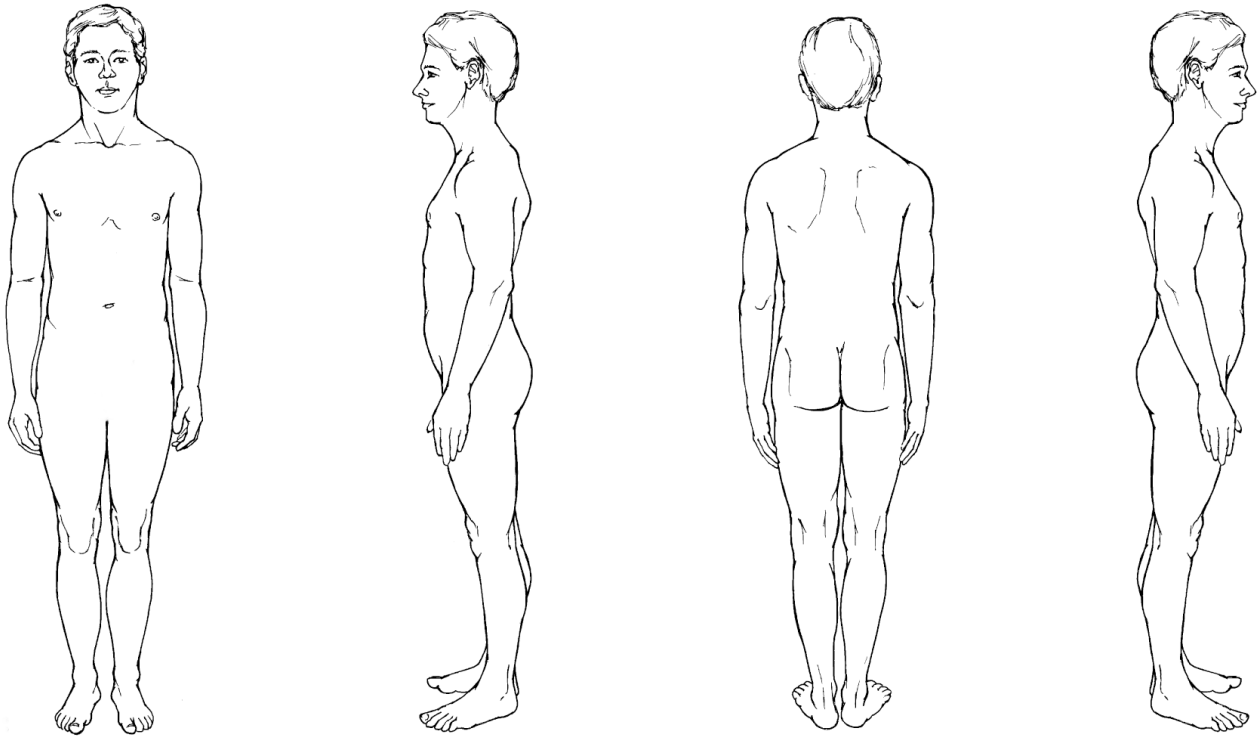
Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes. I understand that my current health may affect how bodywork will affect me. I have told the practitioner everything about my health in order to receive the best care possible. I acknowledge that if I am uncomfortable during the session for any reason, I have the power to stop treatment. I also acknowledge that any disrespectful comments or actions may prevent treatment today.

I am fully committed and responsible for my own health and healing. Yes No

Patient Signature _____ Date _____

PRACTITIONER USE ONLY

SOAP: Subjective/Objective/Action/Plan
Health Assessment by _____



PAIN

POSTURE / GAIT

MOVEMENT / RANGE OF MOTION

MUSCLE TESTING

SKIN / FACE / EYES / TONGUE

FINGERNAILS / TOENAILS / HAIR

NOTES:

RECOMMENDATIONS / HOMEWORK:

FOLLOW-UP VISIT: