Awakening Wellness
Healing Services

Date of first visit: _____ Referred By: _____

Name: _____

Address: _____ City _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

E-mail address: _____

DOB: _____

Age: _____

Number of Children: _____ Age of children: _____

Occupation: _____

General Health History:

List in order of **Most** important to **Least** important areas of pain or dysfunction, whether physical or emotional, you feel are present in your body and need support:

1.

2.

3.

Have you seen a general practitioner, specialist or psychologist for any of these problems? Yes / No

Explain: _____

Was there any treatment or diagnosis given? Yes / No

Explain: _____

Has the condition changed with treatment?

Explain: _____

General Health – please answer or circle appropriate response

General energy level (scale of 1-10, 10 being optimal) _____
Average hours of sleep per night:
Do you wake up feeling refreshed? Yes / No
Do you have difficulty falling asleep? Yes/ No

Do you have depression or anxiety? Yes/ No
Do you feel extreme stress or pressure (general life, work) from day to day? Yes/ No

Do you smoke presently? Yes/ No How long have you smoked?
Have you ever smoked? Yes/ No

Do you drink alcohol? Yes / No How often?
Do you drink coffee? Yes/ No How much per day?
Do you drink soda? Yes/ No How much per day?

How much water do you drink per day in ounces or liters?

Do you exercise regularly? Yes/ No
Types of exercise:

Do you take any vitamin or supplemental products?

Have you been diagnosed with cancer? Yes/ No Type:

Have you ever had any surgeries? Yes/ No

If **Yes** circle type below:
Bone, Tumor, Muscular, Cartilage, Tendon, Organ, Eye, Ear
Implants, Transplants, Pacemakers, Stents, Shunts, Joint replacements?

Cosmetic: Dental, Breast Implants, Breast Reduction, Tummy Tuck, Botox, Fillers, Face Lift,

Have you ever been hospitalized? Yes/ No How long?
Car Accidents? Yes/ No How many?
Broken Bones? Yes/ No Which bones?
Concussions Yes/No How many?
Other head trauma Yes/No How many? What kind?
Sprains or Dislocations? Yes/ No Where?
Any Large Scars? Yes/ No Where?

Other injuries? _____

Please list all medications. Include the conditions it is for.

_____

_____

_____

Musculoskeletal System: Check any areas that currently apply – mark a P for past issue

_____Low back pain
_____Mid-back pain
_____Neck pain
_____Arm pain
_____Leg pain
_____Joint pain
_____Cartilage tears
_____Constant joint stiffness/ache
_____Difficulty walking
_____Broken bones
_____Shoulder pain
_____Torn muscles
_____Muscle strains
_____Ligament sprains
_____Arthritis

Nervous system

_____Numbness/tingling
_____Dizziness or Vertigo
_____Frequent Headaches or Migraines
_____Frequent Muscle Twitching, tics or spasms
_____Seizures
_____Loss of balance
_____Fainting
_____Loss of coordination
_____Hearing problems

Mouth, Throat, Neck

_____Dental crowns, bridges, mouth work
_____Grinding of teeth, TMJ, Clicking Jaw
_____Trouble swallowing
_____ Braces (current or history)

Respiratory System

_____Asthma
_____Chronic/frequent coughing
_____Regular Colds or Infections
_____Pain on breathing
_____Frequent shortness of breath

Cardiovascular System and Peripheral Vascular System

_____High/low blood pressure
_____ Heart murmurs
_____Heart palpitations
_____Varicose veins
_____ Irregular heart beat
_____ Anemia

Gastrointestinal System

_____Frequent Constipation
_____Frequent diarrhea
_____Abdominal pain
_____Colitis, Crohn's Disease, or Ulcers
_____Frequent cramps
_____Frequent indigestion or gas
_____Frequent heartburn

Reproductive System

_____Menopause or peri-menopausal symptoms
_____Frequent cramping_
_____ Pregnant ? (list week if checked)
_____Fibroids, cysts, or endometriosis
_____C-section
_____Irregular cycle

Emotional / Spiritual Health History - write on back if more space is needed.

The tissues of the body hold our story, all of it, even that which we do not remember or want to consciously accept. The healing process requires that we dive into the emotional areas that you are struggling with because the answers and freedom lie with.

Please describe any emotional challenges you are experiencing in your life, [work, relationships, family, finances, etc] as it is right now. Be as thorough as possible:

What are the top 3 goals around the things you listed above that you want to accomplish over the next year?

Who or what do you think is your biggest obstacle in reaching those goals for this year?

What is the biggest challenge you're facing right now?

What motivates you and gifts do you have that you'd like to make available to the world?

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I _____ understand that I am responsible for payment if I cancel within less than 24 hours notice. ____ Initial Here

I request and consent to bodywork treatment from Hilary Bilkis. I understand that these sessions may include components of CranioSacral Therapy and other related modalities such as, but not limited to, Myofascial Release, SomatoEmotional Release, Visceral Mobilization, and Energy Healing.

The purpose of these sessions is to release physical, energetic and emotional restrictions in the body that may be impairing the functioning of all body systems, causing pain, illness or dysfunction.

I understand that treatment requires physical contact with my body.

I understand that the particular therapeutic outcomes of these treatments can not be predicted with certainty and no guarantee can be made regarding any particular result or outcome.

I understand that a series of at least 4 sessions is recommended for optimal results.

This is not a substitute for medical or psychiatric treatment or psychotherapy.

I certify that all medical and social information on the intake form is correct to the best of my knowledge.

Cancellation Policy:

Please give a minimum of 24 hours notice if you are unable to keep your appointment. Otherwise you will be charged $80.00 for this time as it has been specifically reserved for you.

Initial Here _____

Sign: _____

Date: _____