New Client Intake Form
Barbara Pickett DD, CHom, HHP
Call/Text (562) 208-8909 email: pickettsedona@aol.com
www.barbarajpickett.com

Please answer the following as best as you are able and bring it your appointment

Demographics:

Name:_____

Gender Identity: ❑Male ❑Female ☐ Other (Describe if you choose to) :

Address:_____

City:_____ State:_____Zip:_____

Date of birth: _____Age _____ Height _____ Weight_____

Phone Numbers: Home_____Work_____ Cell_____

Email Address: _____

Emergency Contact: Name_____Phone_____

How did you hear about us?_____

Reason for today's visit (Primary Concern (s)_____

When did you first notice this problem?

What if anything makes it better?

What makes it worse?

Do you have a Medical evaluation?

Secondary concerns:

Have you been treated for any of the above with conventional medicine, herbs, acupuncture or any other modality? Please describe.

❑Yes, I am currently under a Physician's care for:_____

_____

_____

_____

Name of Physician:_____ Phone:_____

❑Yes, I am currently taking prescription drugs. Please list below:

Drug Name & Dosage	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

❑Yes, I am currently taking supplements and/or vitamins. Please list below:

Supplement/Vitamin Name & Amount	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

❑Yes, I have an infectious disease. Please describe:_____

❑Yes, I have allergies. Please indicate:

❑Foods – Describe_____

❑Medications – Describe_____

❑Bites/Stings – Describe_____

❑Seasonal – Describe_____

❑Animals – Describe_____

❑Other – Describe_____

Family Medical History (Please check if any of the following applies to any family members)

❑AIDS	❑Alcoholism	❑Allergies	❑High Blood Pressure
❑Asthma	❑Diabetes, Type I or II	❑Heart Disease	❑Cancer
❑Seizures	❑Stroke	❑Mental Illness	❑Other:_____

Describe:

Mother's Health:_____Living/Deceased

Father's Health:_____Living/Deceased

Siblings?_____ Health:_____Living/Deceased

Grandparent's Health:_____Living/Deceased

Personal Health History (Please check if any of the following apply)

❑AIDS	❑Diabetes	❑Hepatitis
❑Alcoholism	❑Emphysema	❑High Blood Pressure
❑Asthma	❑Epilepsy	❑Multiple Sclerosis
❑Allergies	❑Endocrine Disorder	❑Thyroid Disease
❑Arteriosclerosis	❑Gout	❑Childhood Fevers
❑Birth Trauma (yours)	❑Heart Disease	❑Childhood Illnesses

❑Major Surgeries (please list all with approx. dates):_____
_____
_____

❑Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury):_____
_____
_____

Current Symptoms (Please check if any of the following apply)

❑Headaches	❑Urination Difficulties	❑Constipation/Diarrhea
❑Vision Problems	❑Infertility	❑Skin Disorders
❑Jaw/Teeth Pain	❑Impotence	❑PMS
❑Ear Pain	❑Muscular Pain	❑Menstrual Disorders
❑Sinus Pain/Problems	❑Joint Dysfunction/Pain	❑Menopausal Problems
❑Throat Pain/Problems	❑High/Low Blood Pressure	❑Anxiety
❑Breathing Difficulties	❑Depression	❑Chest Pain
❑Chills	❑Overly Emotional	❑Excess Thirst
❑Fever	❑Fatigue	❑Lack of Thirst
❑Indigestion	❑Dizziness	❑Spontaneous Sweating
❑Insomnia	❑Weight Loss	❑Night Sweating
❑Nervousness	❑Weight Gain	❑Lack of Sweating

❑Other:_____

****Please indicate any areas of pain on the diagram located at the end of this form****

Life Style (Please check if any of the following apply)

❑Live Alone	❑Work 9-5	❑Exercise Seldom
❑Live with Spouse/Partner	❑Work 2nd Shift	❑Exercise Occasionally
❑Live with Roommate(s)	❑Work 3rd Shift	❑Exercise Often
❑Live with Parents	❑Work Inconsistent Hours	❑Enjoy Hobby
❑Live with Children	❑Manage Own Business	❑Religious
❑Enjoy your Work	❑Unemployed	❑Spiritual Connection
❑Enjoy your Home	❑Student Full Time	❑Student Part-time
❑Enjoy your Social Life	❑Have Family Support	❑Have Financial Support

Diet and Personal Habits (Please check if any of the following apply)

❑Currently use Tobacco, # packs per Day?_____
❑Currently use alcohol, # drinks per week?_____
❑Former Tobacco Use, Year Quit?_____
❑Currently use recreational drugs
❑Exercise Regularly
❑Vegetarian
❑Vegan
❑Healthy Diet
❑Eat a lot of Fried Foods
❑Eat a lot of Dairy
❑Eat a lot of Sweets
❑Eat a lot of Red Meat
❑Normal weight for Height
❑Underweight
❑Very Overweight
❑Overweight

Please check if you experience any of the following on a regular basis:

Head, Eyes, Ears, Nose, Throat

❑Glasses
❑Ear Ringing
❑Teeth Removed
❑Night Blindness
❑Hearing Loss
❑Numerous Cavities
❑Eye Strain
❑Earaches
❑Teeth Grinding
❑Eye Pain
❑Ringing in Ears
❑TMJ
❑Red Eyes
❑Headaches
❑Gum Problems
❑Itchy Eyes
❑Migraines
❑Lip Sores
❑Spots in Eyes
❑Concussions
❑Mouth Sores
❑Spots in Visions
❑Throat Drainage
❑Excessive Saliva
❑Blurred Vision
❑Throat Tickle
❑Facial Pain
❑Glaucoma
❑Sore Throat
❑Facial Numbness
❑Cataracts
❑Swollen Glands
❑Sinus Problem
❑Nosebleeds
❑Lump in Throat
❑Sinus Drainage
❑Heaviness of Head
❑Enlarged Thyroid

Respiratory

❑Difficulty Breathing
❑Tight Chest
❑Pleurisy
❑Shortness of Breath
❑Asthma
❑Phlegm/Congestion
❑Chronic Cough
❑Wheezing
❑Rattling Sound with Breath
❑Acute Cough
❑Pneumonia
❑Can't Sleep Lying Down

Cardiovascular

❑Hypertension (High Blood Pressure)
❑Blood Clots
❑Hypotension (Low Blood Pressure)
❑Chest Pain
❑Rapid Heart Rate
❑Fainting
❑Palpitations
❑Edema (Swelling)
❑Irregular Heart Rate
❑Slow Heart Rate
❑Pacemaker

Gastrointestinal

❑Nausea
❑Diarrhea
❑Dark Colored Stool
❑Vomiting
❑Constipation
❑Light Colored Stool
❑Acid Regurgitation/Reflux
❑Use Laxatives
❑Mucus in Stools
❑Gas/Flatulence
❑Use Antacids
❑Blood in Stools
❑Hemorrhoids
❑Hiccups
❑Use Fiber
❑Rectal Pain/Itching
❑Bloating
❑Use Digestive Enzymes
❑Fissures
❑Bad Breath
❑Intestinal Pain
❑Bowel Movement 1X/Day
❑Vomiting Blood
❑Poor Appetite
❑Bowel Movement Greater than 1X/Day
❑Bowel Movement Less than 1X/Day

Genito-Urinary

❑Pain with Urination
❑Frequent Urination
❑Urgent Urination
❑Incomplete Urination
❑Increased Libido (Men)
❑Kidney Stones
❑Bed Wetting
❑Wake to Urinate
❑Frequent UTIs
❑Sexually TransDisease
❑Decreased Libido (Men)
❑Impotence
❑Premature Ejaculation
❑Nocturnal Emissions
❑Blood in Urine
❑Dribbling

Musculo-Skeletal

❑Muscle Weakness
❑Muscle Cramps
❑Muscle Spasms
❑Joint Pain
❑Joint Instability
❑Chronic Pain (long-term)
❑Acute Pain (short-term)
❑Injuries
❑Muscle Atrophy
❑Falls
❑Limited Range of Motion
❑Arthritis
❑General Aches
❑Location _____

Neurological

❑Fainting/Syncope
❑Drowsiness
❑Tremor
❑Stroke/CVA/TIA
❑Dizziness
❑Loss of Balance
❑Convulsions
❑Seizures
❑Vertigo
❑Poor Memory
❑Paralysis
❑Numbness

Neurophysiological

❑Depression
❑Irritable
❑Easily Stressed
❑Easily Frustrated
❑Worry Easily – Anxious
❑Unresolved Grief
❑Frightened Easily
❑Numbness
❑Abuse Survivor
❑Receiving Counseling
❑Received Counseling
❑Poor Memory

Skin and Hair

❑Rashes
❑Hives
❑Ulcerations
❑Eczema
❑Fungal Infection
❑Psoriasis
❑Acne
❑Itching
❑Dandruff
❑Premature Graying
❑Hair Loss
❑Hair Changes
❑Hair Breaking
❑Thin Slow Growing Nails
❑Skin Changes

Vitality and Immune System

❑Frequent Colds
❑Frequent Flu
❑Less Ability to Adapt
❑Chronic Mental Cloudiness
❑Low Energy
❑Lethargic
❑Slow Wound Healing
❑Tender/Achy All Over

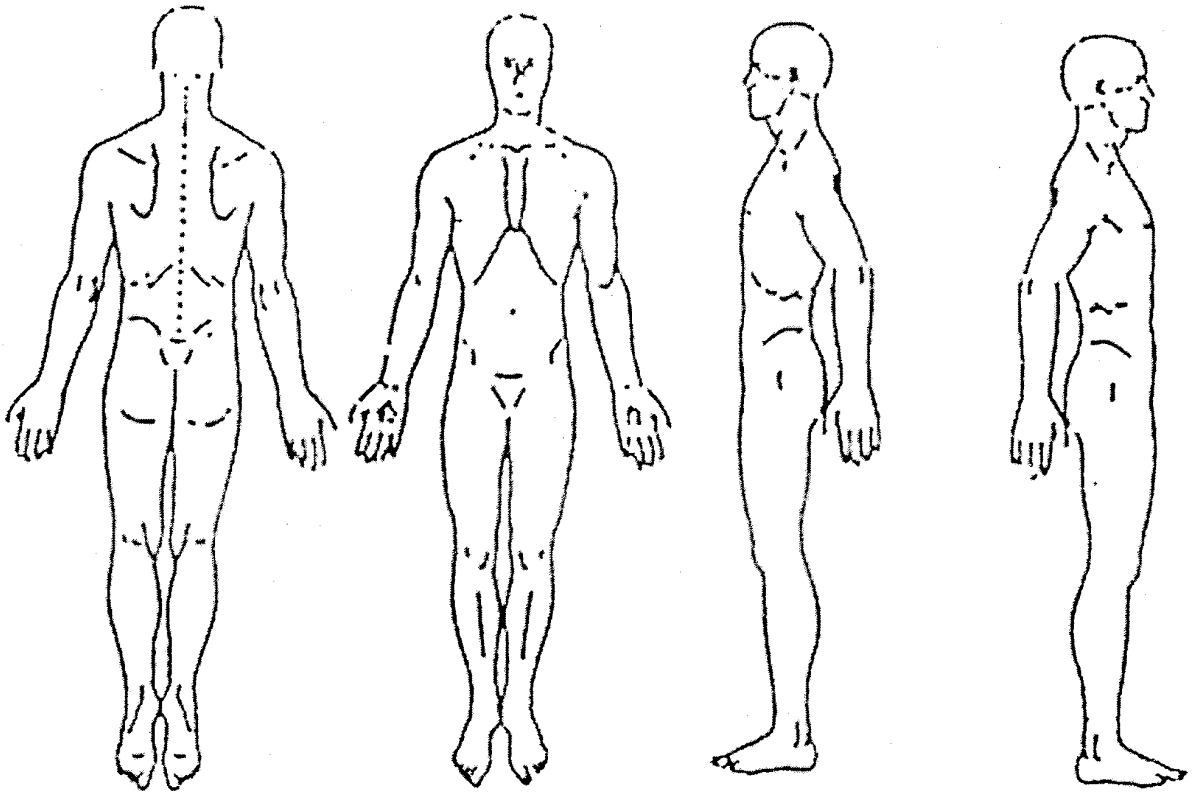
Gynecology ❑N/A

❑Pregnant
❑Could be Pregnant
❑Pregnancies #_____
❑Miscarries #_____
❑Abortions #_____
❑Pre-Mature Births #___
❑Use Birth Control Pills
❑Use Birth Control, Other
❑Use No Contraceptives
❑Use Hormone Replacement
❑Menopausal
❑Peri-Menopausal
❑Decreased Libido
❑Increased Libido
❑PMS
❑Pain Before Menstruation
❑Pain During Menstruation
❑Pain After Menstruation
❑Bone Density Changes
❑Fibrocystic Breasts
❑Breast Lumps
❑Breast Tenderness
❑Mastectomy
❑Lumpectomy
❑Hysterectomy
❑Excess Vaginal Discharge
❑Vaginal Odor
❑Vaginal Sores
❑Vaginal Dryness
❑Vaginal Itching
❑Vaginal Pain
❑Spotting Between Cycles
❑Blood Clots
❑Heavy Bleeding – Weeks
❑Regular Self Breast Exams

--Age of Menarche?_____Yrs/Old
--Age of Menopause?_____Yrs/Old
--Date of Last PAP?_____
--Date of Last Mammogram?_____

Current Menses:
Length of Cycle_____#Days per Month Duration of Flow?_____#Days of Bleeding

Any additional information about yourself (Please write here)



Assessment

Remedies and Doses Selected:

Dietary recommendations

Lifestyle Recommendations

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FAMILY HISTORY Consider all your family members: mother, father, brothers, sisters and grandparents. When writing about a grandparent, please let me know if it is mother's mother (MM) or father's mother (FM), don't simply say grandparent.
(Use back of page or separate sheet if necessary)

Client Name: _____

List how family members have died, from what causes and at what ages:

List family members having had these same conditions including self:

Alcoholism or Drugs:

Allergies:
Anemia:
Arthritis / Gout:
Asthma:
Bleeding problems:
Cancer:
Depression:
Diabetes:
Eczema / Psoriasis / Rashes:
Epilepsy:
Frequent Infections:
Glaucoma:
Heart trouble:
Hepatitis:
High Blood Pressure:
Kidney Problems:
Mental Illness:
Migraines:
Polio:
Pneumonia:
Prostate Problems:
Rheumatic Fever:
Stomach problems:
Stroke:
Thyroid problems:
Tuberculosis:
Venereal Diseases (herpes, syphilis, gonorrhea etc.):

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Timeline: Please write a brief outline of your life history.

Client Name: _____

Beginning with your mother's pregnancy, birth or early childhood, list major illnesses, injuries, hospitalizations, emotional and physical traumas, heartbreaks, divorces, significant turning points or major events in your life.

List any periods of heavy alcohol, cigarettes, caffeine, pharmaceutical or recreational drugs.

For women, please include events related to your reproductive system: first period, menopause, pregnancies, abortion, birth control, etc. Mention any symptoms, which you can relate to these events.

If you are filling it out for your child, please include any notable information about the pregnancy and nursing.

Keep it brief and simple, just the year and the event, we will go into more detail as needed. Please try and write at least one page.

Client Disclosure

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As you know I, Barbara J. Pickett DD, CHom, HHP am a Holistic Health Practitioner providing Energetic Healing Modalities and not a licensed physician, nor are my services licensed by the state. It is recommended that you inform your medical doctor that you are receiving Holistic Energetic Healing. If you ever have any concerns about the nature of these modalities, please feel free to discuss them with me.

Theory: Holistic Energetic Healing is a systematic method of therapy that aims to promote health by reinforcing the body's own natural healing capacity. It may include the practice of providing treatment of the spiritual vital force in accordance with Hahnemanian Principles through the use of remedies that are diluted beyond the concentration of substances in drinking water and prepared in the manner described in the Homeopathic Pharmacopoeia of the Uniited States. The full spectrum of the Client's mental, emotional and physical aspects are vitally important as a modality is selected based on the totality of the symptoms expressed in these areas. Improvement will be evaluated from a full, honest report from the client. As the Spiritual Vital Force is stimulated there may be a brief intensification of the presenting symptoms and/or a temporary return of old symptoms.

Nature of Services The Practitioner relies on a good understanding of the Client; therefore, it is important for you to be as thorough as possible in providing information during your initial consultation. The initial consultation is approximately Two (2) hours and follow up appointments are about Forty-five (45) minutes.

Authorization of Consultation I authorize Barbara Pickett to discuss my case with other professionals should she need assistance in analysis. I understand that my best interest will be served by such a consultation. In doing so, my right to privacy will be protected by changing or withholding my name and all other identifying information.

Confidentiality I understand that all information disclosed in this consultation is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse or a reasonable suspicion that the client presents a danger to themselves or to others. Disclosure may also be required pursuant to a legal proceeding.

Acknowledgement of Information In order to use my services I require that you acknowledge receipt of the information provided in this form and that you sign it.

Acknowledgement and Consent to Receive Services I have read and understand the above disclosure about the Energetic Healing Modalities offered by Barbara J. Picket, and I am aware of her training and education. I have discussed with Barbara the nature of the services to be provided. I understand that she is not a licensed physician and that Energetic Healing Modality services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered by Barbara J. Pickett and agree to be personally responsible for the fees she charges in connection with the services provided to me.

Signature _____ Date _____
Client/Parent/Conservator/Guardian

Printed Name _____