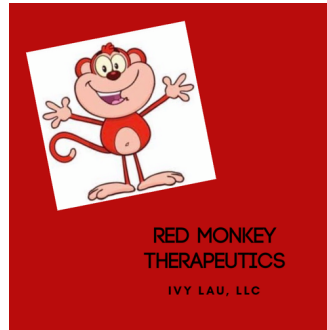


Ivy Lau, MEd, MOTR/L  
Occupational Therapist  
970.880.0090

PO Box 375  
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### New Client Intake Form

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

How were you referred to Ivy?

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Do you have (past or present) any of the following conditions? Circle "Y" for yes or "N" for no.

Heart Condition	Y N	Digestive Problems	Y N
High/Low BP	Y N	Eye, ear, nose, throat disorder	Y N
Allergies	Y N	Contagious or communicable disorders	Y N
Headaches/Migraines	Y N	Disability of feet, ankles, knees, hips, or back	Y N
Cancer	Y N	Numbness and/or tingling in limbs	Y N
Seizures	Y N	Difficulty sleeping	Y N
Thyroid Problems	Y N	Chest pain during exertion	Y N
Osteoporosis	Y N	Excessive fatigue	Y N
Arthritis	Y N	Illness or injury at the present time	Y N
Osteomyelitis	Y N	Contact Lenses	Y N
Asthma/Respiratory Issues	Y N	Dentures / Removable Bridge / Braces	Y N
Chronic Pain	Y N	TMJ Pain or Discomfort	Y N
Circulatory Problems	Y N	Currently pregnant	Y N

Please elaborate on injuries/traumas/accidents/surgeries for which you are currently seeking treatment.

Dates \_\_\_\_\_

Area(s) Affected

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Treatment(s)

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Are you currently under the care of other health care providers? Y / N

What kind of provider(s)? (LMT, DOM, PT, etc.) \_\_\_\_\_

What medications have you taken in the past 6 months?

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What is your previous experience with receiving massage, bodywork, Craniosacral Therapy, etc.?

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What is your reason for seeking integrated, holistic bodywork at this time?

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How would you describe your relationship with your body?

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How would you describe your relationship with your feelings & emotions?

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What kind of support network do you have in your life?

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What are the main stressors in your life?

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Please list 3 goals that you would like to work towards using integrated, holistic bodywork?

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