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INTAKE FORM

Date: ___/___/___ Name: _____

Address: _____ city _____ state _____ zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell phone: (____) _____

E-mail address: _____ Birthdate: ___/___/___

Emergency contact—name and phone _____

Occupation: _____

Physician: _____

Other health care practitioners you are currently working with: _____

Please list any medications you are currently taking, including birth control pills, hormones, homeopathics, herbs, and vitamins/nutritional supplements.

Are you currently under the care of a physician or other health care provider for a specific condition? If yes, please describe.

Are you currently seeing a therapist for a specific condition? If yes, please describe.

Have you ever had surgery? If yes, please describe.

Have you ever had any serious physical injuries? If yes, please describe.

Do you have any skin problems or allergies? If yes, please describe.

Have you experienced any serious illness or disease? If yes, please describe.

How stressful do you feel your life is?

Not stressful at all 1 2 3 4 5 6 7 8 9 extremely stressful

How do you relieve stress?

What other self-care or healing activities are part of your life currently?

Mercury fillings?	Yes	No	
Smoking?	Yes	No	How much daily? _____
Alcohol?	Yes	No	How much daily? _____
Recreational Drugs?	Yes	No	How much daily? _____
Are you pregnant?	Yes	No	If yes, how many weeks? _____
Do you exercise?	Yes	No	Frequency, duration, type? _____

What health conditions have run in your family?

What are your current physical concerns?

What are your current emotional concerns?

What are your current spiritual concerns?

Do you have any needs that require special attention? If yes, please specify.

Other comments: