Gravity Oxygen & CBD

Client Intake Form

Please complete this questionnaire carefully. The information you provide will assist in creating a complete health profile for you.				
All of your answers are absolutely confidential. If you have any questions, please ask.				
			Date:	
Name:			**Male or Female**	
Phone (leave message yes or no):			**DOB:**	
Email:			**Occupation:**	
Address/City/State/Zip:				
Emergency Contact Name/Number/Relation:				
Physician's Name:			**Phone:**	
How did you hear about us?				
Main Complaint (symptoms, diagnosis, duration of condition, etc.):				
Surgeries (please include date of procedure):				
Significant Trauma (auto accident, fall, psychological, abuse, etc.):				
Allergies (drug, food, chemical, environmental):				
Diet: Vegetarian Yes or No	**Meals/Day:**	**Snacks:**	**Caffeine:**	**Alcohol:**
Medications:				
Vitamin Supplements/Herbs:				
Exercise: Days/Week	**Length of Workout:**		**Types of Activity:**	

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Use this space for any additional information that may be relevant, anything else you would like to express, or progress updates.

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Health Questionnaire

Name:			**Male or Female**	**Date:**	
PERSONAL HISTORY: Please circle any conditions or symptoms you have now.					
Arthritis	High/Low Blood Pressure	Cancer	Ulcer	Chronic Fatigue	Fibromyalgia/ Polymyalgia
Gastritis	Liver/Gallbladder Disease	Hypoglycemia/ Hyperglycemia	Diabetes	Seizures	Anemia
Lyme Disease	Asthma	Stroke	Kidney Disease	Food Allergies/ Intolerance	Hepatitis
Thyroid Imbalance	Chronic Pain	Infertility	Heart Disease	Elevated Blood Cholesterol	Diverticulitis/ Irritable Bowls
	Raynaud's Disease	Allergies	Impotence	Emphysema	
Please circle if you have had any of these symptoms listed in the last three months.					
GENERAL:	Poor or Changes in Appetite	Chills	Cravings	Bleed/Bruise Easily	Muscle Weakness/ Fatigue
Poor Sleep	Night Sweats	Localized Weakness	Weight Loss/Gain	Strong Thirst (hot/ cold drinks)	Fatigue
Sweat Easily	Poor Balance	Peculiar Tastes/ Smells	Fevers	Tremors	Dental/Gum Problems
Skin & Hair:	Rashes	Eczema/Psoriasis	Skin Discoloration	Ulcerations	Dandruff
Acne	Hives/Allergic Dermatitis	Hair Loss	Changes in Skin/ Hair Texture	Itching	Face Flushing
Head, Ears, Nose, Throat:	Dizziness	Eye Strain/Pain	Color Blindness	Ringing in Ears	Nosebleeds
Headaches (When/ Where?)	Difficulty Swallowing	Facial Pain	Cataracts	Poor Hearing	Sore Throat/Colds
Dental Problems	Migraines	Poor Vision	Blurred Vision	Seeing Spots	Teeth Grinding
Jaw Clicks/Locks	Eye Glasses	Night Blindness	Earaches	Sinus Problems	Sores on Lips/ Tongue
Cardiovascular:	Chest Pain	Cold Hands/Feet	Shortness of Breath	Irregular Heartbeat	Swelling of Hands/ Feet
Varicose/Spider Veins	Palpitations at Rest	Blood Clots	Pressure in Chest	Fainting	Phlebitis
Respiratory:	Cough	Pneumonia	Difficult to Inhale/ Exhale	Coughing Blood	Pain with Deep Inhalation
	Phlegm	Asthma	Tightness in Chest	Bronchitis	Wheezing
Gastrointestinal:	Nausea	Gas	Indigestion	Bloating/Edema	Vomiting
Belching	Bad Breath	Chronic use of Laxatives	Acid Reflux	Diarrhea	Black Stools
Abdominal Pain/ Cramps	Rectal Pain	Hernia	Constipation	Blood in Stools	Hemorrhoids
Any other problems in the categories listed?					

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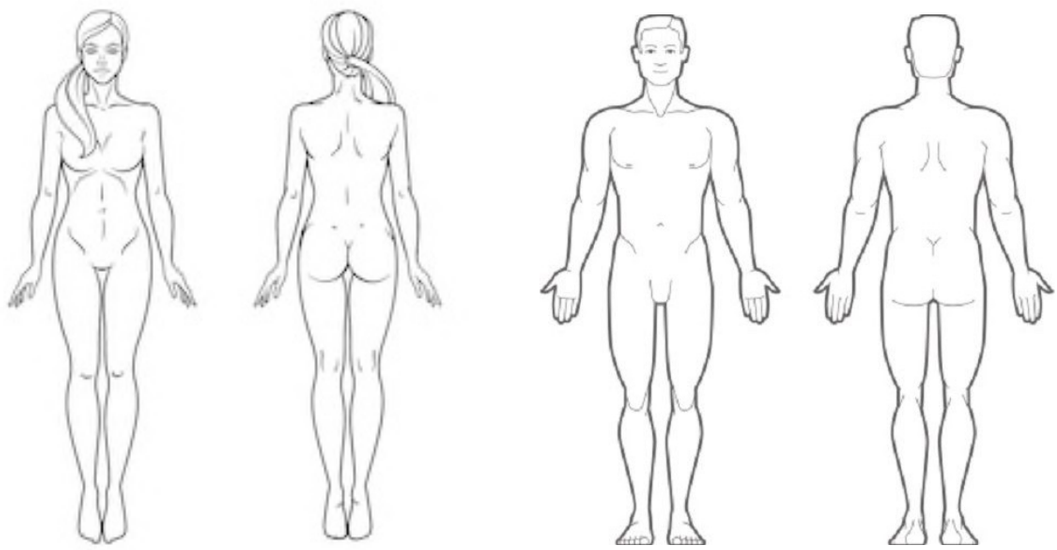
Urogenital:	Painful Urination	Incontanance	Impotence	Premature Ejaculation	Frequent Urination
Kidney Stones	Genital Sores	Decreased Libido	Blood in Urine	Urinary Tract Infection	Prostatitis
	Urgent Urination	Heavy/Sparse Flow	Burning Urination	Urine Leakage	
Gynecological/ Reproductive:	Painful Menses	Irregular Menstruation	Ovarian Cysts	Difficult Intercourse	Breast Lumps
Fibrocystic Breast Tissue	Fibroid Tumors	Infertility	Endometriosis	Menapausal/ PeriMenapausal	Pregnant
Musculoskeletal:	Neck Pain	Knee Pain	Hip Pain	Bursitis	Shoulder Pain
Back Pain - Lower	Back Pain - Middle	Back Pain - Upper	Sprains/Strains	Muscle Pain	Rotator Cuff
Hand/Wrist Pain	Sciatica	Muscle Weakness	Carpal Tunnel	Foot/Ankle Pain	Tendonitis
Neuropsychological:	Concussion	Easily Confused	Easily Susceptible to Stress	Poor Memory	Areas of Numbness
Lack of Coordination	Loss of Balance	Seizures	Vertigo/Dizziness	Bad Temper/ Irritable	Autism Spectrum Disorder
Anxiety/Panic Attacks	Bipolar Disorder	Depression	PTSD	Rage/Tantrums	Schizophrenia
Any other problems not listed?					
Have you ever been treated for emotional problems?					
Do you have a Spiritual Life?					
Have you ever contemplated or attempted suicide?					
Have you been treated for substance abuse?					
Any other neurological or psychological conditions? If yes, please explain:					
On a scale from 1-10, indicate your satisfaction in family relationships.				*Dissatisfied 1 2 3 4 5 6 7 8 9 10 Satisfied*	
On a scale from 1-10. indicate your satisfaction in intimate relationships.				*Dissatisfied 1 2 3 4 5 6 7 8 9 10 Satisfied*	
On a scale from 1-10, indicate your satisfaction in working relationships.				*Dissatisfied 1 2 3 4 5 6 7 8 9 10 Satisfied*	
PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS			***PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS***		



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Brief Pain Inventory

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches).

Have you had pain other than these everyday kinds of pain today? Yes or No

2. Please rate your pain by circling the number that best describes your pain at its **WORST** in the last 24 hours.

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine.*

3. Please rate your pain by circling the number that best describes your pain at its **LEAST** in the last 24 hours.

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine.*

4. Please rate your pain by circling the number that best describes your pain on the **AVERAGE**.

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine.*

5. Please rate your pain by circling the number that tells how much pain you have **RIGHT NOW**.

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine.*

6. What treatments or medications are you receiving for your pain?

7. In the last 24 hours, how much relief have pain treatments or medications provided?

Please circle the percentage below that most shows how much **RELIEF** you have received.

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% *Complete Relief*

8. Circle the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

B. Mood:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

C. Walking Ability:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

D. Normal Work (includes both work outside the home and housework):

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

E. Relations With Other People:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

F. Sleep

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

G. Enjoyment of Life:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 *Completely Interferes*

By Appointment
321-408-2211
CBDbyGravity.com

4311 Norfolk Pkwy #110
West Melbourne, FL 32904
Inside My Salon Suite #204