

**FELDENKRAIS® INSTITUTE NORTHWEST**

Michael E Doren, Guild Certified Feldenkrais Practitioner  
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**Confidential Intake Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Email \_\_\_\_\_ Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_  
Referred by \_\_\_\_\_ Current Physician \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
What results do you want from your Feldenkrais Lesson? \_\_\_\_\_

**Circulatory:** \_\_\_\_\_ **Skin:** \_\_\_\_\_ **Muscles/Joints:** \_\_\_\_\_ **Reproductive:** \_\_\_\_\_  
\_\_ Heart Condition \_\_\_\_\_ Allergies \_\_\_\_\_ Pain \_\_\_\_\_ Pregnant \_\_\_\_\_  
\_\_ Varicose Veins/clots \_\_\_\_\_ Rashes \_\_\_\_\_ Weakness \_\_\_\_\_ Painful Menses \_\_\_\_\_  
\_\_ High/Low Blood Pressure \_\_\_\_\_ Herpes \_\_\_\_\_ Osteo/Rheumatoid arthritis \_\_\_\_\_ Other \_\_\_\_\_  
\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_ Swelling \_\_\_\_\_

**Nervous System:** \_\_\_\_\_ **Digestive:** \_\_\_\_\_ **Surgeries:** \_\_\_\_\_  
\_\_ Headaches \_\_\_\_\_ Constipation \_\_\_\_\_ Within last year Type/Date \_\_\_\_\_  
\_\_ Nerve pain/Numbness \_\_\_\_\_ Bloating/Indigestion \_\_\_\_\_ Prior to last year Type/Date \_\_\_\_\_  
\_\_ Insomnia \_\_\_\_\_ Other \_\_\_\_\_

**Other Conditions:**  
\_\_ Cancer/Tumor \_\_\_\_\_ \_\_ Drug/Alcohol addiction \_\_\_\_\_ Depression \_\_\_\_\_ Diabetes \_\_\_\_\_  
\_\_ Eating Disorder \_\_\_\_\_ \_\_ Anxiety Other \_\_\_\_\_

**Injuries/Accidents (please describe)**  
\_\_ Car/Bike, Falls \_\_\_\_\_  
\_\_ Hospitalizations \_\_\_\_\_  
\_\_ Acute Injuries \_\_\_\_\_  
\_\_ Rehabilitative Therapy Type \_\_\_\_\_  
\_\_ Currently seeing a Medical Practitioner \_\_\_\_\_ Currently seeing a psychotherapist \_\_\_\_\_  
\_\_ Medications (include aspirin, sleeping pills) \_\_\_\_\_

**Exercise/Activities and Frequency** \_\_\_\_\_

I understand that Functional Integration® is provided here for the purpose of movement education.

I understand that the Feldenkrais Practitioner does not diagnose illness, disease, or any other physical or mental disorder; nor does he prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulation.

I acknowledge that Functional Integration® is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for that service.

I have stated all of my known medical conditions and will update the Feldenkrais Practitioner with any changes in my health.

I will honor a 24-hour cancellation policy and am responsible for payment if I cancel within 24 hours.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_