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Confidential Health History Form

Please print and fill out this form and email or fax prior to your first session, or bring with you to the first session.

DATE: _____

NAME _____HOME # _____ WORK # _____ MOBILE#_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

DATE OF BIRTH _____ AGE _____ M ____ F ____ MARITAL STATUS _____

OCCUPATION _____ REFERRED BY _____

EMAIL ADDRESS _____ _____

Please briefly describe what you would like assistance with:

_____

_____

_____

_____

Is there a specific health outcome you would like to receive (if different from your goals listed above)?: Please describe:

_____

_____

_____

_____

HAVE YOU IN THE PAST RECEIVED ALTERNATIVE, SPIRITUAL, OR PSYCHOLOGICAL THERAPIES? PLEASE LIST:

_____

_____

PLEASE LIST THE THERAPIES YOU ARE CURRENTLY RECEIVING: _____

_____

_____

ARE YOU CURRENTLY TAKING ANTI-DEPRESSANTS OR RECEIVING PSYCHOLOGICAL THERAPY? _____

WHEN? _____ BRIEFLY EXPLAIN: _____

LIST MEDICATIONS AND NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING & REASON FOR USE:

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKE N: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

DO YOU HAVE A PERSONAL HEALTH HISTORY OF THE FOLLOWING?

__ TMJ
__ NECK PAIN
__ WHIPLASH
__ HEADACHES
__ DISK PROBLEMS
__ LOW BACK PAIN
__ M ID BACK PAIN
__ SCOLIOSIS
__ IRRITABLE BOWEL
___ EDEMA
___ SEIZURES
___ABDOMINAL PAIN
___ PHLEBITIS
___ ARTHRITIS, BURSITIS
___ STROKE
___ CURRENT SPRAINS
___ HIV/AIDS
___ WEAR CONTACTS
___BREAST AUGMENTATION
___ DIABETES
___ VARICOSE VEINS
___ HIGH BP
___ GOUT
___ DIVERTICULITIS
___ ADD/LEARNING DISABILITIES
___ CHRONIC PAIN
___ CANCER (PLEASE DESCRIBE BELOW)
___ SWELLING OF BRAIN
___ BRAIN HEMORRAGE
___ DEPRESSION
___ BIPOLAR DEPRESSION
___ NERVOUS TENSION
___ ANXIETY DISORDER
___ HORMONE DISORDERS

OTHER IMBALANCES: _____

PLEASE DATE & DESCRIBE ALL MAJOR ACCIDENTS & SURGERIES YOU HAVE EXPERIENCED

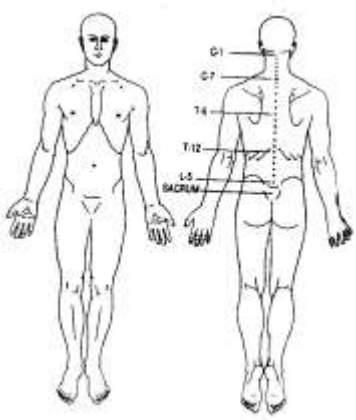
1)_____ _____

2)_____ _____

3)_____ _____

4) _____ _____

CIRCLE AND MARK WITH THE APPROPRIATE NUMBER WHERE YOU ARE EXPERIENCING PHYSICAL PAIN OR IMBALANCE, WITH THE NUMBERS 1 THROUGH 10 (1=BARELY NOTICEABLE, 5 = MODERATE, 10= EXTREME)



PLEASE SHARE MAJOR STRESSES THAT ARE OCCURING IN YOUR LIFE : _____ _____

_____

I acknowledge that the above information is complete and accurate and I will inform Carrie Bodane of any medical changes and changes in medications. I understand that services received by Carrie Bodane, LMBT, MSL are not a replacement for medical care and that no diagnosis will be made.

I understand that by providing this informed consent I am assuming full responsibility for my session and I hold harmless Carrie Bodane and the facility/location where the session is provided.

Cancellation Fee: I agree to pay a cancellation fee for missed appointments or if I cancel the appointment within 24-business hours of the scheduled appointment time. The cancellation fee is equal to the session fee agreed upon when the session was reserved for me. Cancellations via telephone are accepted, and cancellations through email are not accepted.

Dated: _____ Signature: _____