`

Health History

Date:

**Name**  Phone # \_\_

*Last First M. I.*

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date of Birth:*** *\_\_\_\_\_\_\_\_\_\_\_* ***Age:*** *\_\_\_\_\_\_\_* ***Marital Status****: Single / Married / Separated / Divorced / Committed Relationship*

***Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Current Medications****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Children:*** *Yes/No* ***Ages of Children****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Pets:*** *yes/no Type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Are you currently employed****: yes/no* ***Line of work/job Title****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Physician’s Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist’s Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current/ previous treatments for above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Complementary Therapies/Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eating Habits/ Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount daily intake of: Water\_\_\_\_\_\_\_\_ Caffeine\_\_\_\_\_\_\_\_ Alcohol\_\_\_\_\_\_\_\_\_\_ Cigarettes/Tobacco\_\_\_\_\_\_\_\_ Sugar\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your Exercise Routine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Reason for visit or presenting complaint:*** *Date of on set: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Additional Questions

1. Please list any injuries you had or have:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Please list any surgeries you had or know you will have:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Please list any traumatic or life threatening events that occurred in your life and when they happened:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. What do you hope for and what are your expectations from this healing today and long term?

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. What alternative health therapies have you experienced (e.g., Reiki, Acupuncture, Healing Touch, massage, etc.)

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Do you consider yourself a spiritual person Yes/No?
2. What spiritual practices do you engage in (e.g., meditation, prayer, church, yoga, Tai Chi, etc)

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Is there anything else you want to share or want me to know?

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HAVE YOU HAD?** | **Past** | **Current** | **HAVE YOU HAD?** | **Past** | **Current** |
| **Cardiovascular System** |  |  | **Musculo-Skeletal System** |  |  |
| **Heart Murmur** |  |  | **Bone Injuries** |  |  |
| **Heart Palpitations** |  |  | **Joint Injuries** |  |  |
| **Angina** |  |  | **Muscle injury** |  |  |
| **Heart Attack** |  |  | **Arthritis** |  |  |
| **Heart Failure** |  |  | **Bursitis** |  |  |
| **High Blood Pressure** |  |  | **Tendonitis** |  |  |
| **Low Blood Pressure** |  |  | **Carpal Tunnel** |  |  |
| **Stroke** |  |  | **Back Pain** |  |  |
| **Aneurism** |  |  | **Joint Pain** |  |  |
| **Anemia** |  |  | **Gout** |  |  |
| **Bleeding Disorders: Hemophilia/Other** |  |  | **Fibromyalgia** |  |  |
| **Other:** |  |  | **Muscle Cramps** |  |  |
|  |  |  | **Osteoporosis** |  |  |
|  |  |  | **Other:** |  |  |
| **Respiratory System** |  |  | **Auto-Immune System** |  |  |
| **Seasonal Allergies/Hay Fever** |  |  | **AIDS / HIV** |  |  |
| **Asthma** |  |  | **Allergies** |  |  |
| **COPD** |  |  | **Cancer (type)** |  |  |
| **Pneumonia** |  |  | **Tumor** |  |  |
| **Bronchitis** |  |  | **Chronic fever** |  |  |
| **Tuberculosis** |  |  | **Fatigue** |  |  |
| **Emphysema** |  |  | **Fungal Infections** |  |  |
| **Smoker** |  |  | **Herpes (type)** |  |  |
| **Other:** |  |  | **Lyme Disease** |  |  |
|  |  |  | **Mononucleosis** |  |  |
|  |  |  | **Skin Disorder (type)** |  |  |
|  |  |  | **Other:** |  |  |
| **Gastrointestinal System** |  |  | **Endocrine System** |  |  |
| **Stomach Aches** |  |  | **Thyroid Disorder** |  |  |
| **Constipation (chronic)** |  |  | **Pituitary Disorder** |  |  |
| **Diarrhea (chronic)** |  |  | **Thalamus Disorder** |  |  |
| **Hepatitis** |  |  | **Hyper Thyroid** |  |  |
| **Gastritis** |  |  | **Hypo Thyroid** |  |  |
| **Jaundice** |  |  | **Adrenal Fatigue** |  |  |
| **Hypoglycemia** |  |  | **Other:** |  |  |
| **Ulcers** |  |  |  |  |  |
| **Reflux Disease** |  |  | **Reproductive System** |  |  |
| **IBS** |  |  | **Sexually Transmitted Disease** |  |  |
| **Diabetes** |  |  | **Peri Menopausal** |  |  |
| **Liver Disorder** |  |  | **Post menopausal** |  |  |
| **Gall Bladder Problems** |  |  | **Endometriosis** |  |  |
| **Other:** |  |  | **Fertility Issues** |  |  |
|  |  |  | **Pregnancies (number)** |  |  |
| **Other** |  |  | **Miscarriage (number)** |  |  |
| **Victim of Sexual Assault** |  |  | **Abortions (number)** |  |  |
| **Victim of Violence** |  |  | **Other:** |  |  |
| **HAVE YOU HAD?** | **Past** | **Current** | **HAVE YOU HAD?** | **Past** | **Current** |
| **Emotional/Psych** |  |  | **Neurological System** |  |  |
| **Depression** |  |  | **Recurrent Headaches** |  |  |
| **Anxiety** |  |  | **Migraines** |  |  |
| **Phobias** |  |  | **Epilepsy** |  |  |
| **Mood Swings** |  |  | **Seizures** |  |  |
| **Panic Attacks** |  |  | **Parkinson’s Disease** |  |  |
| **Obsessive Compulsive Disorder** |  |  | **Shingles** |  |  |
| **Bipolar** |  |  | **Dizziness** |  |  |
| **Suicidal Thoughts** |  |  | **Concussion** |  |  |
| **Insomnia** |  |  | **Multiple Sclerosis** |  |  |
| **Eating Disorder** |  |  | **Bell’s Palsy** |  |  |
| **Substance Abuse (type)** |  |  | **Chronic Fatigue Syndrome** |  |  |
| **Stress** |  |  | **Chronic Pain** |  |  |
| **ADD** |  |  | **Dementia** |  |  |
| **ADHD** |  |  | **Lupus** |  |  |
| **Grief** |  |  | **Meningitis** |  |  |
| **Personality Disorder (type)** |  |  | **Head/Neck Injury** |  |  |
| **Other:** |  |  | **Other:** |  |  |
| **ENT** |  |  | **Urinary System** |  |  |
| **Sinus Problem** |  |  | **Bladder Infection** |  |  |
| **Eye Problem** |  |  | **Kidney Infection** |  |  |
| **Ear Problem** |  |  | **Kidney Stones** |  |  |
| **Throat Problem** |  |  | **Blood in Urine** |  |  |
| **Jaw Pain** |  |  | **Bladder Control** |  |  |
| **Gum Disease** |  |  | **Other:** |  |  |
| **Other:** |  |  |  |  |  |

Statement of intent:

The Brennan Healing Science work that I am practicing helps to clear and charge the human energy field, to remove energetic blocks that may lead to dis-ease and to enhance the body’s natural healing capability. I will be doing healing energy work both with my hands on the body and also through the Human Energy Field which surrounds the body. The work is done with you being fully clothed and lying on the healing table.

**I do not and am not licensed to medically diagnose or prescribe treatment.** If you have a physical injury or disease condition, I ask that you be in the care of a licensed medical professional. I do not advise you to discontinue any medical treatment you may be receiving.

Self-care is an extremely important part of this work and is your responsibility during our work together. If at any time during the session you are uncomfortable, please inform me immediately. I also recommend that you refrain from using alcoholic beverages for 24 hours following our practice session.

My hourly rate is $\_\_per hour $\_\_\_ for an hour and half. If you need to cancel please do so prior to 24 hours before our session. If you do not, you will be charged for your scheduled time.

Any information you share with me during our session is always kept confidential. I may, however, discuss practice clients, without mentioning their names, with my professional supervisors, for the purpose of my continuing professional development and so that clients may receive the best assistance available.

Thank you for including me in your healing journey.