Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: (circle one)

Single Married Divorced Widowed

If married please provide spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If divorced or widowed for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? \_\_\_\_\_\_\_\_ yes no

If yes, please list their names and ages and whether they are currently living with you:

Name Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names, Addresses and Phone Numbers for:

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any Therapeutic or Spiritual Growth Experience you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications &/or supplements you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now or have you ever been on any psychotropic drugs? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Intake (# of glasses per week): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_yes \_\_\_\_\_\_\_\_\_\_ no

If yes, the number of cigarettes smoked in 24 hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine consumption: (# of cups of coffee/tea/soda pop per day) \_\_\_\_\_\_

Daily water intake (# of 8 oz. glasses) \_\_\_\_\_\_

General type of diet: \_\_\_\_\_\_

Type of exercise and frequency per week: \_\_\_\_\_\_\_\_\_\_\_\_\_

Vision: \_\_\_\_\_\_\_\_\_\_\_ Do you wear glasses \_\_\_\_\_\_\_\_\_\_\_\_\_

Sense of smell: \_\_\_\_\_\_\_\_\_\_\_ Hearing: \_\_\_\_\_\_\_\_\_ Touch: \_\_\_\_\_\_\_\_\_\_ Taste: \_\_\_\_\_\_\_\_\_\_

Do you wear a wig, toupee or hairpiece? \_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_\_ no

Please list all accidents &/or injuries in your life:

List all diseases or illnesses that run in your family and the family member who corresponds with that illness:

Illness: Relationship:

Have you ever had bodywork before? \_\_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_\_\_ no

If yes, what type of bodywork?

Childhood:
Were your parents ever separated or divorced? \_\_\_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_\_\_ no

If yes, with whom did you live? \_\_\_\_\_\_\_\_\_\_\_

How old were you at the time? \_\_\_\_\_\_\_\_\_\_\_

Did you ever live with anyone other than your parents? \_\_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_\_ no

If yes, with whom did you live and at what age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check which of the following you have had. If this is a current issue for you please indicate that with a “C”.

\_\_\_\_ Constipation \_\_\_\_ Fatigue \_\_\_\_\_ Fungal Infections

\_\_\_\_ Diarrhea \_\_\_\_\_ Bronchitis \_\_\_\_\_ Herpes Simplex I

\_\_\_\_ Flatulence \_\_\_\_\_ Emphysema \_\_\_\_\_ Herpes Simplex II

\_\_\_\_ Indigestion \_\_\_\_\_ Pleurisy \_\_\_\_\_ Gonorrhea

\_\_\_\_ Acid Reflux \_\_\_\_\_ COPD \_\_\_\_\_ Syphilis

\_\_\_\_ Gastritis \_\_\_\_ Chicken Pox \_\_\_\_ HPV

\_\_\_\_ Dysentery \_\_\_\_\_ Measles \_\_\_\_\_ Chlamydia

\_\_\_\_ Dizziness \_\_\_\_\_ German Measles \_\_\_\_\_ Ulcers

\_\_\_\_ Migraines \_\_\_\_\_ Mumps \_\_\_\_ Allergies – Seasonal

\_\_\_\_ Headaches \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Excema

\_\_\_\_ Ear Aches \_\_\_\_\_ Jaundice \_\_\_\_\_ Psoriasis

\_\_\_\_ Jaw Pain \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_Dandruff

\_\_\_\_ Back Pain \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Heart Disease

\_\_\_\_ Hypertension \_\_\_\_\_ Malaria \_\_\_\_\_ High Blood Pressure

\_\_\_\_ Depression \_\_\_\_\_ Tuberculosis \_\_\_\_\_Low Blood Pressure

\_\_\_\_ Mood Swings \_\_\_\_\_ Arthritis \_\_\_\_\_ Cancer (list type)

\_\_\_\_\_ Insomnia \_\_\_\_ Diabetes \_\_\_\_\_ Leukemia

\_\_\_\_\_ Epilepsy \_\_\_\_\_ Stroke \_\_\_\_\_ Incontinence

\_\_\_\_\_ Menopause \_\_\_\_\_ Liver Problems \_\_\_\_\_ Pancreatitis

\_\_\_\_\_ Hypoglycemia \_\_\_\_\_ Tonsillitis \_\_\_\_\_ Menstrual Cramping

\_\_\_\_\_ HIV \_\_\_\_\_ Bladder Infections \_\_\_\_\_ Joint Problems

\_\_\_\_\_ AIDS \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Kidney Stones

\_\_\_\_\_Rheumatoid Arthritis \_\_\_\_\_ Osteo Arthritis \_\_\_\_\_ Lyme Disease

\_\_\_\_\_ Bursitis \_\_\_\_\_ Teeth Problems \_\_\_\_\_ Gum Disease

\_\_\_\_\_ Personality Disorder \_\_\_\_\_ Emotional Issues \_\_\_\_\_ Addiction (sugar fat food)

Other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your blood type? \_\_\_\_ A- \_\_\_\_\_ B+/- \_\_\_\_\_ AB+/- \_\_\_\_\_ O+/-

What are your goals and expectations from today’s healing?

What are your long-range goals from healing therapy?

CONSENT FOR TREATMENT & POLICIES

The purpose of this consent explains my work and how it can aid in your overall health.

My belief about healing is the body can self-correct and healing comes from within each of us. I can assist you in your healing by doing various kinds of treatment that will balance your energy and enhance your sense of well-being. I use energy work, massage, Structural Integration (deep tissue massage), Reflexology, Trager Psychophysical Integration, Cranial Sacral Therapy and may work on or off your body.

We will discuss the major stresses in your life, your belief systems, health history, your childhood, nutrition and other issues that have an influence on your emotional, physical and spiritual wellness. All discussions are confidential.

I may recommend some dietary or lifestyle changes. You may implement them if you choose. I am not a physician and do not diagnose diseases or prescribe drugs. I am a certified body worker. I do not advise you to discontinue any medical treatment you might be receiving. My work is intended to be in harmony with any other healing work you undertake including traditional medicine. Please feel free to discuss our work with you doctor. At all times your healing is your responsibility.

*I prefer to set up a regular schedule of appointments. However, there is never an obligation to continue treatment. I require 36 hours notice should you need to cancel an appointment. Payment in full is expected for any session you might miss or cancel with less than 36 hours notice. (Please initial that you have read and understand this cancellation policy: \_\_\_\_\_\_\_\_\_)*

In signing the Acknowledgement and Release on the next page you agree that I may work with you in the above described manner.

 ACKNOWLEDGEMENT AND RELEASE

The client hereby acknowledges he or she has read the foregoing Consent for Treatment, understands the nature of the sessions and freely elects to receive treatments. The client releases Joyce Belmonte from any and all claims of malpractice, non-disclosure or lack of informed consent. The client freely assumes any and all risks for the treatment whether presently contemplated or hereinafter discovered.

The client further releases \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to contact other professionals as necessary for the client’s recovery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client-

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date