THE BODY IS A SELF HEALING ORGANISM

Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Birthdate _____

Telephone Home _____ Cell _____ Work _____

Emergency Contact _____ Referred by _____

Occupation _____

What do you want from this session? _____

Where do you constantly store discomfort in your body? _____

Have you had or do you have:

Hernia	Cancer	Headaches
Pelvic Pain	Head Injuries	Falls to Buttocks
Sexual Abuse	Physical Abuse	Emotional Abuse
Pregnant	Heart Problems	Kidney Stones
Joint Pain	High Blood Pressure	Fatigue
Allergies	Other Traumas	Other

Please explain:

_____

_____

Please advise me of any accident, surgeries or scars from any time in your life: _____

_____

Are you currently under the care of a physician or chiropractor - if so, for what condition? _____

_____

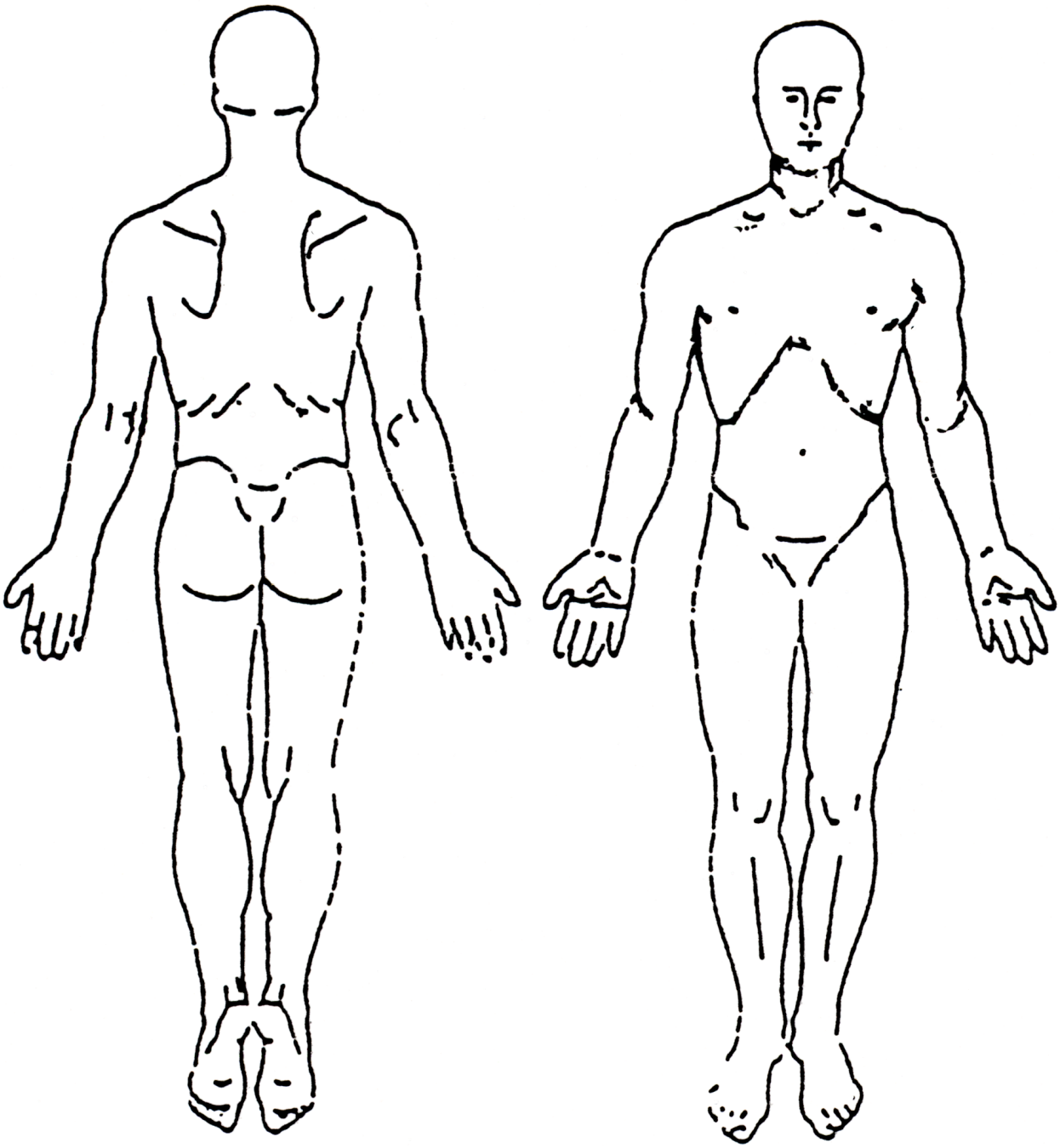
_____

Are you interested in learning some self help techniques? yes / no _____

☐ To avoid being charged in full for your session, if you miss it, 24 hours notice is required.

Bodyheart Therapy is honored and committed to be a part of your care/maintenance and education. I am happy to share with you my awareness and knowledge, however, I do not diagnose.

SIGNATURE _____ DATE _____



PLEASE PLACE A ✓ IN FRONT OF EACH ITEM THAT YOU EXPERIENCE AT LEAST MONTHLY, PLACE AN X IN FRONT OF EACH ITEM THAT YOU EXPERIENCE WEEKLY OR MORE FREQUENTLY.

_____ Headaches (type?)
_____ Heart pounding or racing
_____ Irregular heart beat
_____ Chest pain, tightness
_____ Numbness, tingling in arm or leg
_____ Can't keep warm enough
_____ Sweaty palms
_____ Blushing, flushing face
_____ Coughing
_____ Stuffy nose, congestion
_____ Earache or ringing noise in ears
_____ Common colds
_____ Sore throat
_____ Asthma or shortness of breath
_____ Hay fever or allergies
_____ Sore, aching muscles
_____ Stiff or tender joints
_____ Back problems
_____ Trembling / twitching muscles
_____ Skin rashes, eruptions
_____ Grinding of teeth (TMJ)
_____ Dry mouth
_____ Mouth sores
_____ Excessive perspiration
_____ Difficulty falling asleep
_____ Difficulty sleeping through night
_____ Awaken too early in morning
_____ Excessive drowsiness during day
_____ Periods of extreme fatigue
_____ Feeling faint or dizzy
_____ Feeling tense or nervous
_____ Difficulties with family or friends
_____ Worrisome thoughts
_____ Recurring bad thoughts
_____ Thoughts of suicide
_____ Fearful of persons or places

_____ Feeling inadequate / unable to cope
_____ Feeling guilt or failure
_____ Uncontrolled crying or sadness
_____ Easily annoyed / irritated
_____ Free-floating anxiety about life
_____ Voice quivering, shaking
_____ Eyes irritated or inflamed
_____ Vision blurred
_____ Eyestrain or discomfort
_____ Nosebleeds
_____ Stomach cramps
_____ Heartburn – indigestion
_____ Nausea or vomiting
_____ Frequent urination
_____ Incomplete urination
_____ Painful urination
_____ Urinary leakage
_____ Bowel leakage
_____ Gas in lower bowel
_____ Diarrhea
_____ Constipation
_____ Bowel irregularity
_____ Uninterested in sexual relations
_____ Unable to enjoy sexual activity
_____ Unable to participate in sex acts
_____ Menstrual difficulties
_____ Pre-menstrual Syndrome
_____ Breast tenderness
_____ Hot Flashes
_____ Water retention
_____ Over-eating / bingeing
_____ Lack of appetite
_____ Excessive alcohol abuse
_____ Other substance abuse
_____ Frequent laxative use
_____ Other:

MEDICATIONS: Please indicate below ALL medications which you are currently taking, the problem for which you are using them and the dose and their effectiveness:

Medication:	For Treatment of:	Dose/Amt/Day:	Effectiveness:

bodyHeart therapy

PATIENT DISCLOSURE

Please disclose any indication of having been exposed to COVID-19, or whether you hae experienced any signs or symptoms associated with the COVID-19 virus.

Patient's Name _____

Date _____

Do you have a fever? YES / NO

Do you have trouble breathing? YES / NO

Do you have a dry cough? YES / NO

Have you recently lost or had a reduction in your sense of smell? YES / NO

Have you been in contact with someone tested positive for COVID-19? YES / NO

Have you tested positive for COVID-19? YES / NO

Have you traveled outside the United States by air or cruise ship in the past 14 days? YES / NO

Have you traveled within the United States by air, bus, or train within the past 14 days? YES / NO

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature _____ Witness _____

Email _____

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