Balance Integrative Care

Illness and Pain Management through Mind and Body

Initial Information

Name_____ Date of Birth_____ Age_____ Gender Identity_____

Address_____ City_____ State___ ZIP_____

Preferred Phone_____ Email_____

May I leave a message? Yes No

Relationship Status_____ Occupation_____

Emergency Contact_____ Phone _____

May I leave a message? Yes No

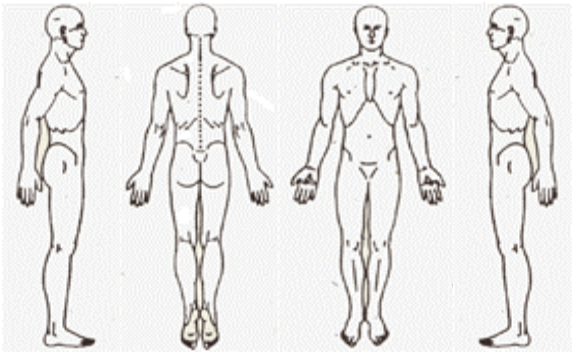
Relationship to Client_____

If your doctor or another healthcare practitioner referred you, please provide practitioner's name and phone number:

Practitioner_____ Phone_____

Primary Concern

Is there an area of the body where you are experiencing tension, stiffness, pain, other discomfort? Please indicate:



Do you experience difficulties with any of the following?

Physical	Mental	Emotional	Social
Sleep	Memory	Fears	Withdrawal
Eating	Concentration	Worries	Relationship
No energy	Decisions	Sadness	
Restlessness	Confusion	Worthlessness	
Excess energy	Paranoia	Guilt	
	Hallucinations	Hopelessness	
	Flashbacks	Euphoria	
		Grief	
		Irritability	
		Temper outbursts	
		Low motivation	

Is there anything else you think may be helpful to know?_____

Estimate the severity of above problem: Mild Moderate Severe Very severe

Lifestyle Issues

Do you experience unmanaged stress in your work, family, other aspects of your life?	YES	NO
Do you sit for long periods of time at a workstation, computer, or while driving?	YES	NO
Do you perform repetitive movements in your work, sports, hobby?	YES	NO
Do you exercise on a regular basis?	YES	NO
Do you use tobacco products?	YES	NO
Do you drink alcohol?	YES	NO
Do you drink beverages with caffeine in them?	YES	NO

How much water do you drink on an average day?_____

Medical and Mental Health Concerns

Please list any injuries, surgeries, medical or mental health diagnoses (past and present) and your age at the time of injury/surgery/diagnosis:

Injuries/Surgeries/Diagnoses	Age
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking prescription medication, herbal remedies, over-the-counter medication, vitamins? YES NO

If yes, what do you take?_____ Reason?_____

Have you ever been hospitalized for medical or mental health reasons? YES NO

If yes, why?_____ When?_____

Receipt of Practice Policies and Privacy Notice

I have received Practice Policies and Privacy Practices for Balance Integrative Care; I understand them and agree to comply with them.

_____

Client/Guardian Name (print) **Date** **Signature**

Consent

I, _____,(print name) understand that the services I receive are provided for the purpose of pain management, relaxation, and/or relief of muscular tension and emotional concerns. I understand that during treatment, unpleasant memories, feelings, or thoughts may occur resulting in emotional discomfort. Since collaboration with medical may be indicated prior to and/or throughout treatment, I affirm that I have stated all my known medical and mental health conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I agree to give 24-hour notice for a scheduled session that I am unable keep. I am aware that I may be charged for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

_____

Client/Guardian Name (print) **Date** **Signature**