Health And Well Being History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Other Phone:
Cellular Phone:	Referred by:
Date:	Date of Birth:

PART 1.

* Please answer the following questions honestly and to the best of your ability.

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, and if so when?

What are your goals from BodyTalk?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is _____:	◯ None	◯ Minimal	◯ Moderate	◯ Severe

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often? _____

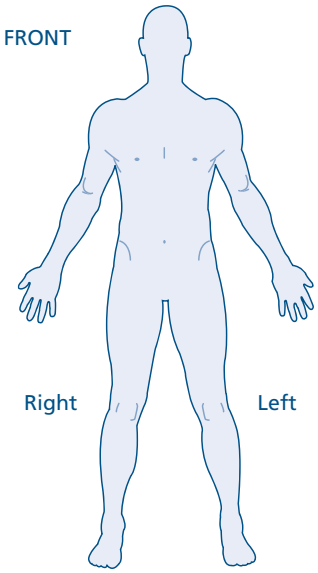
How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain: _____

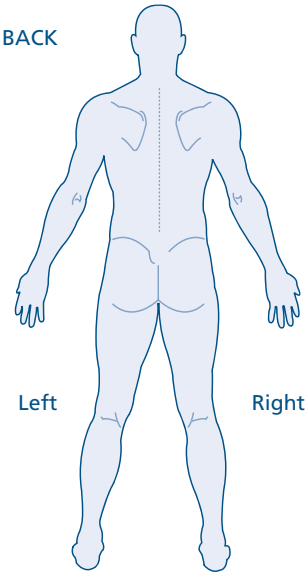
* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

1 2 3 4 5 6 ● 8 9 10 example: neck	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.





COMMENTS:

Client signature:

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Practitioner's comments:

BodyTalk

Janet Galipo, AP, DOM, Adv. Sr. CBI

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Patient Registration/Notice of Privacy Practice

In Case of Emergency, Who Should Be Notified: _____

Home Phone: _____ Cell phone: _____ Work phone: _____

Where or From Whom Did You Hear About Us? _____

NOTICE OF PRIVACY PRACTICE & PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at anytime and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This Consent was signed by: _____

Printed Name – Patient or representative: _____

Relationship to Patient (if other than patient): _____

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Treatment Consent Form

I _____, hereby voluntarily consent to be treated by BodyTalk and/or Acupuncture administered by Janet Galipo, a certified BodyTalk Practitioner and Acupuncture Physician licensed in the State of Florida.

I understand that the BodyTalk sessions provided by this Certified BodyTalk Practitioner are intended to enhance relaxation, increase communication within the areas of the body, and to educate me to possible energetic or emotional blocks that may create pain and disease. BodyTalk is non-invasive, safe, and objective. It utilizes the body's own innate intelligence to reestablish communication within itself.

I understand that BodyTalk is not a substitute for medical treatment or medications. I am aware that the BodyTalk Practitioners does not diagnose illness or disease nor does the Practitioner prescribe medications.

I understand that Acupuncture is performed by the insertion of special needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body's function and/or relieve pain.

I have been made aware that certain adverse side effects may result from Acupuncture. These could include bruising, some pain or discomfort, weakness, fainting, nausea, and the possible temporary aggravation of symptoms existing prior to the treatment. This last effect, however, should be considered beneficial and not adverse in that it indicates that the so-called "law of Cure" is occurring – i.e;, that suppressed imbalances are being released.

I certify that I understand all of the foregoing including the discussion of my treatments and procedures involved, and that all questions which I have asked have been answered.

_____
Patient's Signature (or Guardian)

Age: _____ Date: _____