CARRIE W. BODANE, LMBT
Minister of Soulful Living
Phone: 919/874-0060 Fax: 919-870-5225
letsascend@gmail.com www.TransformandAscend.com

Confidential Health History Form

Please print and fill out this form and email or fax prior to your first session, or bring with you to the first session.

DATE: _____

NAME _____ HOME # _____ WORK # _____ MOBILE#_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

DATE OF BIRTH _____ AGE _____ M ____ F ____ MARITAL STATUS _____

OCCUPATION _____ REFERRED BY _____

EMAIL ADDRESS (For notifications. Email address will not be shared.) _____

Please briefly describe what you would like assistance with:

_____

_____

_____

_____

Is there a specific health outcome you would like to receive (if different from your goals listed above)?: Please describe:

_____

_____

_____

_____

HAVE YOU IN THE PAST RECEIVED ALTERNATIVE, SPIRITUAL, OR PSYCHOLOGICAL THERAPIES? PLEASE LIST:

_____

_____

PLEASE LIST THE THERAPIES YOU ARE CURRENTLY RECEIVING: _____

_____

_____

ARE YOU CURRENTLY TAKING ANTI-DEPRESSANTS OR RECEIVING PSYCHOLOGICAL THERAPY? _____

WHEN? _____ BRIEFLY EXPLAIN: _____

LIST MEDICATIONS AND NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING & REASON FOR USE:

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKE N: DAILY ____ AS NEEDED ____
MEDICATION REASON

_____ _____ PRESCRIPTION BEGAN _____ TAKEN: DAILY ____ AS NEEDED ____
MEDICATION REASON

DO YOU HAVE A PERSONAL HEALTH HISTORY OF THE FOLLOWING?

__ TMJ	___ EDEMA	___BREAST AUGMENTATION	___ CANCER (PLEASE DESCRIBE BELOW)
__ NECK PAIN	___ SEIZURES	___ DIABETES	___ SWELLING OF BRAIN
__ WHIPLASH	___ABDOMINAL PAIN	___ VARICOSE VEINS	___ BRAIN HEMORRAGE
__ HEADACHES	___ PHLEBITIS	___ HIGH BP	___ DEPRESSION
__ DISK PROBLEMS	___ ARTHRITIS, BURSITIS	___ GOUT	___ BIPOLAR DEPRESSION
__ LOW BACK PAIN	___ STROKE	___ DIVERTICULITIS	___ NERVOUS TENSION
__ M ID BACK PAIN	___ CURRENT SPRAINS	___ ADD/LEARNING DISABILITIES	___ ANXIETY DISORDER

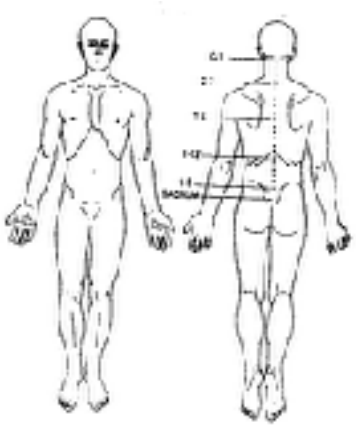
__ SCOLIOSIS ___ HIV/AIDS ___ CHRONIC PAIN ___ HORMONE DISORDERS
__ IRRITABLE BOWEL ___ WEAR CONTACTS

OTHER IMBALANCES: _____

PLEASE DATE & DESCRIBE ALL MAJOR ACCIDENTS & SURGERIES YOU HAVE EXPERIENCED

1)_____
2)_____
3)_____
4) _____

CIRCLE AND MARK WITH THE APPROPRIATE NUMBER WHERE YOU ARE EXPERIENCING PHYSICAL PAIN OR IMBALANCE, WITH THE NUMBERS 1 THROUGH 10 (1=BARELY NOTICEABLE, 5 = MODERATE, 10= EXTREME)



PLEASE SHARE MAJOR STRESSES THAT ARE OCCURING IN YOUR LIFE : _____ _____

_____

I acknowledge that the above information is complete and accurate and I will inform Carrie Bodane of any medical changes and changes in medications. I understand that services received by Carrie Bodane, LMBT, MSL are not a replacement for medical care and that no diagnosis will be made.

I understand that by providing this informed consent I am assuming full responsibility for my session and I hold harmless Carrie Bodane and the facility/location where the session is provided.

Cancellation Fee: I agree to pay a cancellation fee of $50 for missed appointments or if I cancel the appointment within 24-business hours of the scheduled appointment time. Cancellations via telephone are accepted, and cancellations through email are not accepted.

Dated: _____ Signature: _____