Statera Therapies

Confidential Health Client Health and Wellbeing Intake Form

All answers given will aid in reveiving the best possible treatment. Please fill out as honest and as in depth as you can. All information is considered confidential.

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

Part 1. Please answer the following questions to the best of your ability

Describe the problem(s) for which you seek help. Please include the dates when each problem occurred, and how long you have been experiencing the problem:

_____
_____
_____

Please describe your past medical history (injuries, accidents, surgeries, illnesses, conditions) including approximate dates.

_____
_____
_____

List the medications and supplements that you are presently taking, and the condition you are taking them for.

_____
_____
_____

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

_____
_____
_____

What are your goals for the appointment?

_____
_____
_____

Please list any other kind of health care professional you are seeing/have seen for this/these problem(s):

_____
_____
_____

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

_____
_____
_____

Part 2. Please mark the symptoms that you experience

Digestion:

◯ Loose stool or diarrhea	◯ Acid reflux	◯ Nausea/vomiting	◯ Poor appetite
◯ Constipation	◯ Heartburn	◯ Difficulty digesting oil	◯ Excessive appetite
◯ Gas or belching	◯ Stomach or intestinal pain	◯ Blood in stool	◯ Other:

Respiratory:

◯ Allergies	◯ Catch colds easily	◯ Sinus problems	◯ Do you smoke?
◯ Asthma	◯ Congestion nasal or chest	◯ Shortness of breath	◯ Number per day_____
◯ Dry cough	◯ Wheezing	◯ Chest tightness	◯ Nose bleeds
◯ Wet cough	◯ Other:		

Circulation Cardiovascular:

◯ High blood pressure	◯ Slow heart rate	◯ Too hot	◯ Dizziness
◯ Low blood pressure	◯ Chest pain	◯ Too cold	◯ Water retention
◯ Fast heart rate	◯ Palpitations	◯ Cold hands/feet	◯ Other:

Urinary:

◯ Painful urination	◯ Incontinence	◯ Difficulty urinating	◯ Kidney stones
◯ Kidney infections	◯ Other:		

Other:

◯ Difficulty learning	◯ Numb/tingling. Where?__	◯ Thirsty	◯ Poor sense of taste
◯ Difficulty paying attention	◯ Muscle weakness	◯ No thirst	◯ Poor sense of smell
◯ Difficulty with speech	◯ Difficulty walking	◯ Dry mouth	◯ Poor hearing
◯ Development/growth issues	◯ Shaky	◯ Difficulty swallowing	◯ Fatigue
◯ Poor coordination	◯ Dry eyes	◯ Anemia	◯ Insomnia
◯ Loss of balance	◯ Eye pain	◯ Eczema	◯ Headaches
◯ Lots of sleep. No hours? _____		◯ Watery eyes	◯ Skin condition
◯ Nightmares	◯ Migraines	◯ Poor vision	◯ Joint swelling
◯ Nose bleeds	◯ Abdomen/thorax pain	◯ Other eye problems?	◯ Other

Women Only:

◯ Pregnant? How far along?_____		◯ Are your cycles regular? ◯ PMS
◯ Length of cycle: _____		◯ Painful menses
◯ Heavy or excessive flow	◯ Breast pain or tenderness	◯ Other:

Part 3. Wellbeing, Emotions and Stress

a: Please circle any of the following feelings you have experienced in the past few months.

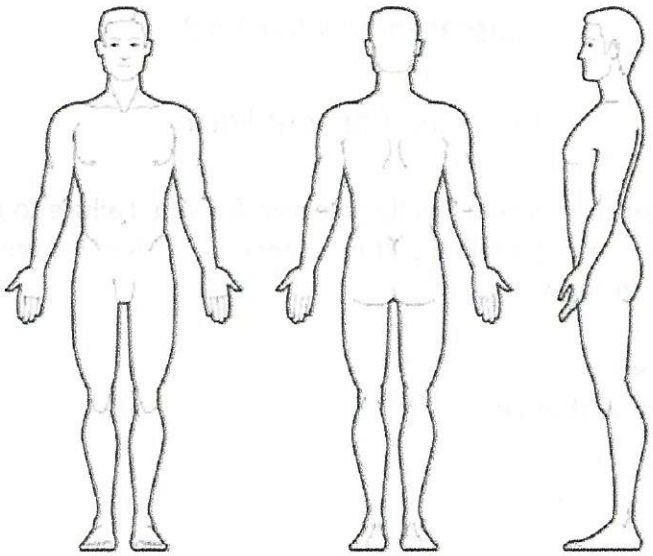
Emotional	Despair	Helpless	Uneasy	Distress	Fearful	Angry
Panic	Guilty	Sad	Paranoid	Muddled	Grief	Nervous
Worried	Restless	Criticized	Rejected	Agitated	Impatient	Persecuted
Apprehensive	Overwhelmed	Intimidated	Depressed	Easily Irritated	Overworked	Aggravated
Uncertainty	Annoyed	Outraged	Obsessive	Indecisive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

b:Please mark your level of stress from the listings below.

Family stress is:	◯None	◯Minimal	◯Moderate	◯Severe
Relationship stress is:	◯None	◯Minimal	◯Moderate	◯Severe
Work stress is:	◯None	◯Minimal	◯Moderate	◯Severe
Financial stress is:	◯None	◯Minimal	◯Moderate	◯Severe
Health stress is:	◯None	◯Minimal	◯Moderate	◯Severe
Other stress is:	◯None	◯Minimal	◯Moderate	◯Severe

Part 4. Pain.

Please mark areas of pain/discomfort on the body diagrams and make comments on the side if necessary.



Please rate your pain level on the line below

no pain _____ **pain as bad as it could be**

1 2 3 4 5 6 7 8 9 10

Personal Habits:

Alcohol Servings/Week	7+____	4-6____	1-3____	0____
Coffee/Tea/Soft Drinks/Day	4-5____	2-3____	1____	0____
Tobacco/Day (packages)	1____	¾____	½____	0____
Exercise/Week	4-7____	3____	1-2____	0____

Types of exercise/activities:_____

Comments: _____

_____

_____

_____

_____

_____ _____

Patient Signature Date

Statera Therapie
Unit B 924 Northumberland Avenue
Saskatoon, Sk S7L3W8

Informed Consent Form

Please note: your appointment time is specifically reserved for you. Failure to give a minimum of 3 hours notice to cancel this appointment will result in a cancellation fee. Failure to show up to this appointment will result in a "no show" fee.

Cancellation fees are as follows:
$10.00 less than original treatment price.

_____
Signature
Thank you for your co-operation and understanding!

I understand that the Accunect, BodyTalk and Reiki sessions offered by: Christina Booth are not a replacement for medical treatment when necessary

I understand that the purpose of the session is to increase my own conscious and subconscious awareness of areas where my body can manage its own self-healing more effectively on all levels, mind, body and spirit.

I also understand that no medical diagnosis or prognosis of recovery can be given on the basis of consciousness based healing and Accunect, BodyTalk and Reiki, therefore, I will not interpret any statements by the above named practitioner as a diagnosis or prognosis of my condition.

By signing my signature below, I agree to sessions from the above named practitioner with this understanding.

Print Name of Client:_____

Signature:_____ Date:_____

Print Name on Signature:_____
(if different from client)