Health/Well Being History and Consent Form

I, _____, understand that BodyTalk is intended to enhance relaxation, increase communication within areas of the body, and to educate me to possible energetic or emotional blocks that may create pain or disease. I also understand I *may* experience so-called "detoxification symptoms" during the 24-48 hours following the BodyTalk session and that these may be somewhat uncomfortable, particularly if I have been experiencing chronic or heightened levels of stress. I acknowledge that The BodyTalk System is non-invasive, safe, and objective. It utilizes the body's own innate intelligence to re-establish communication within the body-mind complex. I understand that BodyTalk entails light tapping and touching of energy points on the body. The BodyTalk Practitioner will inform me where tapping and/or touching (by the practitioner and/or myself) will occur, thus allowing for my ongoing consent.

I acknowledge that BodyTalk is not a substitute for medical treatment or medications. I am aware that the BodyTalk Practitioner does not diagnose illness or disease, nor does the Practitioner prescribe medications. I understand that information exchanged during any session is educational in nature and is to be used at my own discretion, and that any information imparted during these sessions is strictly confidential in nature and will not be shared with anyone without my written permission.

I understand that by providing this informed consent I am assuming full responsibility for my BodyTalk session and I hold harmless both the BodyTalk Practitioner and the facility/location where the session is provided. **Since time has been especially reserved for me, I understand a 72-hour cancellation notice is expected and missed appointments will be charged.** If I have any questions or concerns, I will address these promptly with the BodyTalk Practitioner.

I hereby authorize **Jill Kirby,** Certified BodyTalk Practitioner, to provide me with BodyTalk session(s).

_____ _____ _____
SIGNATURE DATE PHONE

_____ _____ _____
ADDRESS EMAIL DATE OF BIRTH

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

Describe the issue(s) for which you seek help. Please include dates when each symptom 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 concerns:

_____

_____

Have you ever had this issue 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 issue(s):

_____

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

_____

Your birth: vaginal delivery or caesarean? Were you breast or bottle fed?

Vaccinations? (which ones and when)_____

Antibiotics: How often?_____ When did you last have antibiotics?_____

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

Abused Criticized Overworked Paralyzed Depressed Rejected Despair Helpless Hopeless

Paranoid Overwhelmed Muddled Persecuted Guilty Easily irritated Anxious Sad Grieving

Unable to grieve Apprehensive Agitated Uneasy Distress Fearful Impatient Intimidated Restless

Panic Intolerant Uncertainty Aggravated Annoyed Angry Outraged Nervous Worried

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

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 to relax and what do you do to relax (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 circle the conditions you experience and rate them accordingly.

1. Rarely (once a month or less) **2. Occasionally** (less than once a week)

3. Frequently (more than once a week) **4. Constantly** **Leave blank if there is never a problem**.

DIGESTION

Loose stool or Diarrhea	Constipation	Poor digestion	Parasites	Acid reflux
Stomach or intestinal pain	Gas or belching	Heartburn	Excessive appetite	Poor appetite
Difficulty digesting oily food	High cholesterol	Gall stones	Irritable bowels	Hemorrhoids

Light colored stool Black or dark stool Blood in stool Nausea / vomiting

RESPIRATORY

Emphysema Bronchitis Wet cough Dry cough Chest tightness

Congestion Wheezing Sinus problems Allergies Hay fever

Catches colds easily Asthma Pneumonia Poor sense of smell Shortness of breath Nasal problems

Other: _____ Do you smoke? yes no Number per day: _____

CARDIOVASCULAR

Hypertension Hypotension Chest pain Easily bruised Cold hands / feet Dizziness

Edema Heart palpitation Slow heart rate Poor circulation Sweaty hands / feet Heart disease

Phlebitis Anemia Blood clots Restlessness Poor blood clotting

Heart attack ...How many times? ____ Stroke....How many times? ____

URINARY

Painful urination Incontinence Difficulty with urination Ringing in ears Ear aches Hearing impairment

Kidney stones Kidney infections Knee problems Low back pain Other: _____

NERVOUS SYSTEM

Dyslexia Learning disorder Multiple Sclerosis Muscular dystrophy Epilepsy Head injury

Numbness, Where?_____ Tingling, Where?_____

Nervous disorder?Type: _____ Developmental or growth problems? _____

MUSCLES / JOINTS

TMJ pain Facial pain Poor coordination Leg Weakness Arm Weakness Trunk Weakness

Difficulty walking Osteoarthritis Rheumatoid Arthritis Joint swelling Artificial joints Loss of Balance

Broken bones, fractures? _____ Pins, etc? yes no _____

Please circle the painful areas, and indicate on which side: (R) right and / or (L) left

Shoulder R L Arm R L Elbow R L Hands R L Legs R L Knee R L Foot R L

Upper back R L Mid back R L Low back R L Hip R L Limited movement? Where _____

OTHER

Fever Dizziness Headaches Migraines Fibromyalgia Pain at night Soft or brittle nails

Eye pain Chills Fatigue Dry eyes Watery eyes Nose bleeds Easily angered

Dental problems Poor hearing No thirst Excessive thirst Dry mouth Diabetes Weight gain/Weight loss

Tuberculosis Thyroid problems Herpes Shingles Shaky Anxiety Insomnia

Poor memory Depression Candida Swollen glands Difficulty swallowing Poor sense of smell

Poor sense of taste Difficulty with speech Obsessive tendencies in work relationships

Difficulty making plans or decisions Difficulty paying attention Intolerance to temperature /weather changes

Cancer, Where?_____

Allergies? List:_____

Hepatitis? type: ____ Infectious disease:_____ Other eye problems?_____

Chemical dependency_____ Skin condition: ____yes no _____

Sleep too much, how long?_____

WOMEN ONLY

Breast pain or tenderness Breast lumps Nipple discharge Painful intercourse Ovarian cysts Endometriosis

PMS Infertility Menopause/Menopausal symptoms:_____

Are your cycles regular? Length of cycle: _____ Painful menses with heavy or excessive flow

MEN ONLY

Prostate problems Pain associated with genitals Impotence Problems urinating

Infertility Prostate cancer

Jill Kirby, CBP, BAT

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