Personal Record

All information provided is kept confidential.

Name:____

Pronouns: ____

Date of Birth:____

Email:____

Phone:____

Text number, if applicable:________________________________

Address:____

____

Significant Relationships:_________________________________

____

____

Guardian information, if applicable:___________________________

____

____

Occupation:____

Emergency Contact

Name:____

Phone:____

Relationship:____________________________________

Referred By:____

Fill in the following information to the best of your ability. Please provide ages or dates whenever possible. If more space is needed, please continue on the back, or attach an extra page.

1. When you were born, was it a difficult birth? **Y N** Very rapid birth? **Y N**
C-section? **Y N** Forceps? **Y N** Full Breach birth (actually born feet first)? **Y N**
Comments:

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2. Have you ever had blows to the head? (Need not have caused unconsciousness. Examples: Fall from a bicycle or down stairs, car or sports accident, object hitting head, etc.) **Y N** If yes, please list age/date and describe what happened. Describe any problems experienced afterward.

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3. Have you ever experienced a "whiplash"? **Y N** If yes, please indicate what happened and what you experienced afterward.

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4. Have you ever had any fractures, sprains, or other sports or auto injuries? **Y N** If so, please list them with approximate date(s) or age(s).

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5. Surgeries? **Y N** Please list, with approximate dates(s) or age(s).

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6. Have you ever experienced chiropractic manipulation? **Y N**
If so, was it for(circle): Neck Upper/Mid Back Low Back Other:_________________

Are you currently receiving adjustments? **Y N**
Chiropractor's Name:

____

____

If you know the type of chiropractic you are receiving, please list:

____

____

7. Are you taking any medication? **Y N** Under a doctor's care for any reason? **Y N**
If so, please list:

____
____
____
____
____

8. What is your blood type? _____ Have you ever had any transfusions? **Y N** When?_____________

9. If you receiving other kinds of healing modalities, please list them. This gives me the ability to suggest support from other practitioners in the event that may be helpful.

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10. Describe your diet. (Check the ones that most aptly describe your eating pattern and elaborate in the space provided.)

☐ red meat ☐ vegetarian (no meat)
☐ chicken or fish ☐ vegan (no meats, eggs, or dairy)

List any relevant dietary information here:

____
____
____
____
____

11. Are you taking any of the following? Please indicate brands and quantity

☐ vitamins ______________________________ ☐ homeopathic remedies _______________
☐ minerals ______________________________ ☐ herbs______________________________
☐ phytochemicals _______________________ ☐ enzymes ___________________________
☐ antioxidants ___________________________ ☐ other______________________________

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12. Do you use any of the following? (Please indicate amounts and frequency.)

☐ alcohol______________________ ☐ sugar____
☐ coffee_______________________ ☐ marijuana / delivery______________________________
☐ tobacco_____________________ ☐ other recreational drugs___________________________

13. Do you have, or have you ever had:

☐ chicken pox	☐ bronchitis	☐ hepatitis	☐ pacemaker
☐ measles	☐ rheumatic fever	☐ HIV or AIDS	☐ cancer__________________
☐ mumps	☐ pneumonia	☐ herpes	☐ vaccinations
☐ scarlet fever	☐ asthma	☐ heart attack	☐ other___________________

14. Do you have allergies? **Y N** Do any other members of your family have allergies? **Y N**

Please list known allergies and sensitivities

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____

____

15. Number of pregnancies___ Number of children____ Contraception used _______________

16. Do you have any of the following symptoms? List other symptoms on next page.

____headaches
____stiff neck
____upper back pain
____lower back pain
____sciatica (pain down leg)
____knee pain
____foot/ankle pain
____elbow pain
____hip pain
____fatigue
____anxiety
____attention deficit problems
____learning difficulties
____rapid heartbeat
____very low blood pressure
____tachycardia
____light-headedness
____eye pain/dryness
____ringing ears/earache
____diminished sense of smell
____diminished sense of taste
____equilibrium problems
____wrist/hand pain
____sinus congestion
____dimin. immune response
____panic attacks
____trouble thinking/focusing
____hungry right after eating
____hard to take deep breath
____ feeling “too full to eat”
____high cholesterol (LDL)
____anemia
____heartburn
____intestinal gas
____intestinal pain
____difficulty swallowing
____constipation
____tickling in throat
____pain in/behind sternum
____shoulder pain
____TMJ (jaw) problems
____frequent colds/flu
____feeling of “weakness”
____hyper-activity
____”fuzzy”-headedness
____high blood pressure
____high triglycerides
____osteoporosis
____cysts
____difficulty urinating
____kidney stones
____coordination problems
____dental cavities
____feeling “on edge”
____craving sugar
____seizures
____diarrhea
____arthritis
____frequent urination
____gall stones
____depression
____psoriasis
____dental abscess
____feeling of “impending doom”
____parasites known/suspected
____swollen glands
____trouble sleeping
____tumors
____burning with urination
____accident prone
____acne
____periodontitis
____heel pain
____numb/tingling in fingers

Any symptoms not listed that you would like to add?

____

Current concerns that brought you here today

If you have specific problems or concerns, please list them here. Indicate when and how the problem started, as well as any diagnosis and treatment received thus far. Did it help, or is it helping?

If you have no particular pain or problems, but are interested in improved energy and sense of well-being, enhanced immune response and/or early detection/prevention of problems, please indicate that!

To the best of my knowledge, I have listed all of my past and current conditions.

Signature ____ *Date*______________________

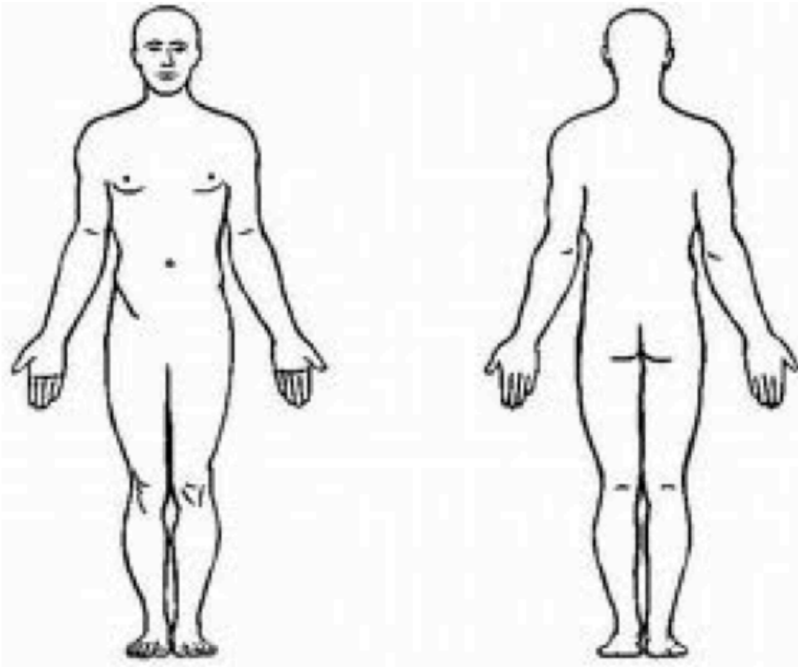
*Guardian Signature*_________________________________ *Date*______________________

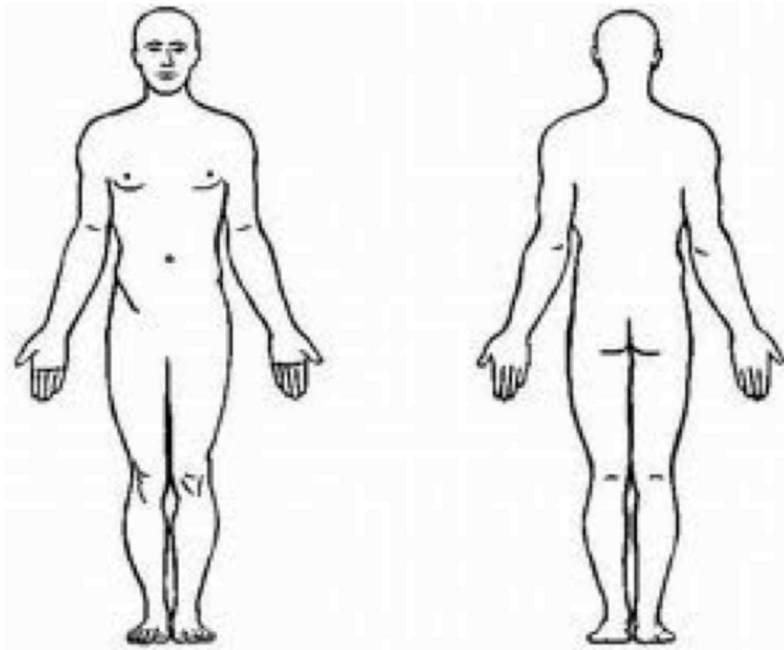
Thank you!

Name ____Date____________________

Mark as specifically as possible where you experience pain:

You may use more than one set of figures if levels of pain vary or different types of pain occur at different times.





Confidentiality

Information shared within the context of this professional relaitonship shall remain confidential.
Limits of confidentiality
Elizabeth Terrel is a mandated reporter, which requires reporting

1. Client’s threat of suicide, when reporter considers it a risk.
2. Credible threat to others, with children and the elderly as particular concern.

I understand these limits of confidentiality

____
Signature Date

____
Guardian Signature Date

Professional Relationship Understanding

I understand that Elizabeth Terrel is a Voice & Movement Professional, a Quantum Energetics Structured Therapy practitioner, a 500RYT Yoga Teacher, and a coach.
I understand that she is not a medical doctor.
I understand that the work she performs is based on the practices of Voice & Movement methodologies, QEST Technique, and Yoga and that it is not a medical diagnosis.
I understand that nutritional recommendations are not prescriptions, but are recommended on the basis of the above referenced pedagogies.
I understand that for medical diagnosis I should consult with a medical doctor.

Claims: I understand that no specific claims or guarantees are being made as to the outcome or result of my sessions. Results can vary as do individuals.

Insurance: I understand that Elizabeth Terrel will not bill insurance, and that determining coverage for her services is between me and my insurer.

Privacy: I understand that all information is shared in confidence and will not be released to anyone without my specific written permission. The exception to this privacy understanding is if she suspects that I pose a threat to myself or others.

Personal Responsibility: I understand that I have the right to take or refuse any advice given. I assume full responsibility for my use of any services and information provided.

Independent Relationship: I understand that this is a professional relationship. This Client/Practitioner relationship is independent of any other forms of relationship that may exist between us as individuals (example: teaching relationship, colleagues, friends, etc.) and is not influenced by and does not influence these other relationships.

____
Signature Date

____
Guardian Signature Date

Office Policies

It is recommended that the client have a medical doctor as their primary care physician. Elizabeth Terrel is a Voice & Movement professional, a Quantum Energetics Structured Therapy Practitioner, and a mental health professional operating under supervision.

In an emergency or an acute situation, your doctor is best suited to meet your needs. Call 911 and manage the emergency before pursuing other treatments.

Payment is required at the time of the visit. Payments can be made by Venmo, cash, or check. Credit card payment is possible, and incurs a nominal fee.

At this time, these services are not covered by insurance.

Office visits are by appointment only. If you are late, your session will be given in whatever time remains. If you need to cancel a session, 24 hours notice is required to avoid a charge.

Fees: Initial Consultation and Session (1 ½ - 2 hours) 180.00
**please arrange your schedule to allow for 2 hours in case we need it*

Following Sessions (50 minutes) 95.00

Phone Consultation 95.00/hr
(plus any toll charges)
*phone charges apply to nutritional and/or physical counseling calls in excess of 10 minutes

House calls generally incur an additional charge including fees for travel time. Please discuss this with your practitioner in advance.

There may be occasional nutritional recommendations, the majority of which can be purchased at grocery or health food stores. These are not included in the fee schedule.

I have read, understand, and agree to the Office Policies.

____
Signature Date

____
Guardian Signature Date

What to expect

Unless otherwise arranged, the first appointment will take approximately 1 ½ hours. Following appointments will be 50 minute sessions, unless longer appointments are agreed upon. If you are traveling a considerable distance for your sessions, longer appointments may be a good option for you.

Be sure to bring all paperwork to your first appointment. We will review your Personal Record and the accompanying agreements together. If you encounter questions you don't know how to answer, we will discuss them together to determine relevant information.

Please wear comfortable clothing. Sweats or yoga wear are ideal. You will remain clothed, so you want to be comfortable lying down, rolling over, etc. If your feet tend to get cold, bring socks.

You may be tired after your session — and you may not. Some people have lots of energy after a session, and some are exhausted, There's no way to tell ahead of time how your body will process our work together. For that reason, you may wish to schedule demanding or stressful appointments on another day, particularly for the first two sessions.

Avoid recreational drugs 24 hours before your appointment. Alcohol should not be in your system at the time of your appointment. If you are on a prescription pain-killer, please discuss it with me before your appointment.

If you have any questions before your appointment, do not hesitate to call.