Allen Therapies

734 Country Way, Scituate, MA 02066, 781-545-5392, pattyallen@verizon.net

Thank you for choosing to come to see me. The programs I use are designed to enhance your health. In order to facilitate the success of your treatment, the following questions are necessary to help me in working with you, by familiarizing me with your expectations and past medical history. If there is anything additionally that you would like me to know, please don't hesitate to tell me. The information that you disclose here is kept strictly confidential.

Name: _____ Today's date: _____

Address: _____ Date Of Birth: _____

City: _____ State:_____ Zip_____

E-Mail Address:_____ Occupation: _____

Home Phone: _____Work Phone: _____Cell Phone:_____

How did you hear about me?_____

If referred by someone, whom should I thank? _____

What type of therapy are you receiving today? _____

Have you ever received any of the following treatments (please check)?

__ Massage Therapy, __ CranioSacral Therapy, __ Visceral Manipulation, __Chiropractic, __ Homeopathy, ___Acupuncture

Are you currently taking any medications? If so, please list the name and purpose of each: _____

_____

_____

_____

Have you ever had any type of surgery? If so, please give type, date and reason: _____

_____

_____

_____

What diseases are in your family history: _____

_____

_____

_____

If you have pain, please tell us where? _____

What is it's intensity, from 1 – 10? ____ When did it start? _____

What was the cause? _____

Describe it: Sharp Ache Constant Sporadic W/movement W/touch W/breath

What is the main reason for your therapy session today? _____

_____

Are you under a doctor's care currently? ___ If so, for what condition and what treatment are you receiving? _____

_____

How often do you have bowel movements? _____

Please examine the following list. If you have <u>not had the listed condition, then leave it blank.</u> If however you <u>have the condition currently, please put "C"</u>, or if you <u>have had the condition for more than a few days in the past, please put "P".</u>

General Conditions							
Allergies		Anemia		Cancer		Candidiasis (yeast)	
Eating Disorders		Headaches		Hernia		Infections	
Pacemaker		Food Poisoning		Antibiotics		Tumors/Cysts	
Insomnia		Mononucleosis		Peridontal Disease		Immunodeficiency	
Gastro-Intestinal & Renal Conditions							
Appendicitis		Belching		Bloating/Gas		Blood in Stool	
Burning Anus		Colitis		Constipation		Crohn's Disease	
Diarrhea		Diverticulitis		Flatulence		Gastritis	
Gall Stones		Heartburn		Hemorrhoids		Hepatitis/Liver	
Nausea		Parasites		Ulcers		Vomiting	
Frequent Urination		Gout		Kidney		Bladder	
Endocrine & Glandular Conditions							
Adrenal Glands		Body Odor		Diabetes		Hypoglycemia	
Libido/Sex Drive		Pituitary Gland		Thyroid Gland		Weight Gain/Loss	
Cardiovascular & Respiratory Conditions							
Angina		Arteriosclerosis		Blood Clots		High/Low Blood Pressure	
Cholesterol		Cold Hands/Feet		Edema		Heart Problems	
Phlebitis		Varicose Veins		Asthma		Bronchitis	
Chronic Cough		Emphysema		Pneumonia		Breathing Difficulty	
Neurological & Emotional Conditions							
A.L.S.		Anxiety		Dyslexia		Depression	
Epilepsy		Fatigue		Hostility		Irritability	
Memory Loss		Mood Swings		Multiple Sclerosis		Myasthenia Gravis	
Numbness		Parkinson's Disease		Schizophrenia		Sciatica	

Female/Male Conditions							
Impotence		Menstrual Problems		PMS Syndrome		Pregnancy	
Prostate		Vaginal Discharge		Venereal Disease			
Musculo-Skeletal & Connective Tissue Conditions							
Fibromyalgia		Arthritis		Bursitis/Tendinitis		Herniated Disc	
Fractures		Joint Dislocation		Jaw Tension/TMJ		Joint Stiffness	
Lupus		Scars		Scoliosis		Whiplash	
Eyes, Ears, Nose & Throat Conditions							
Bad Breath		Bad Taste in Mouth		Cataracts		Coated Tongue	
Contact Lenses		Deafness		Earaches		Foggy Vision	
Glasses		Glaucoma		Hoarseness		Light Sensitivity	
Narrowed Vision		Nasal Discharge		Sore Throat		Sinus Problems	
Please tell me which of the following you include in our weekly diet:							
Nuts/Seeds		Dairy		Butter/Margarine		Processed Foods	
Legumes/Beans		Red Meat		Chicken		Fish	
Fried Foods		Salt		Vegetables		Fruit	
Bread		Grains		White Sugar/Flour		Oils	
Coffee		Tea		Soda		Beer/Alcohol	
Soy Products		Protein Powder		Sauces		Fast Food	

Do you exercise regularly? _____ If so, what type: _____

What do you do for stress management? _____

Is there anything else you feel I should know in order to treat you?

_____

_____

_____

It is your responsibility to disclose to me, your therapist, any and all past and present medical conditions, and you release Me from any and all liability due to injury or other causes resulting from the exercise of my duties. You understand that all treatments given are done so by a qualified therapist and you expressly give permission for the treatments received and understand that the services offered are not a substitute for medical care. If you have any questions regarding the appropriateness of the therapy given, we advise you to seek the advice of your physician before receiving treatment.

I understand the Ear Candling service is designed to be a health aid and is in no way to take the place of a doctor's care when it is indicated. This is an ancient method of gently and naturally removing wax and debris from the ear canal. I, the person receiving this service, assume full responsibility.

Please sign below to give permission for the treatment to be received.

Client Signature: _____Date: _____

Payment and Cancellation Policy

Payment is expected on the day of service. Because I make my self available to you by appointment, I ask that you give 24 hours notice when you must cancel and appointment so that I may offer the time to another client. If you are unable to do this, you will be billed for the missed appointment. I hope you understand this courtesy to me and to my other clients.

Thank You, Patty