SACRED WINDS CENTER
FOR HEALING

Permission To Treat and After Care

The primary objective of Sacred Winds is to create an atmosphere of trust and safety to enable you, the patient, to heal as optimally and efficiently as possible. This requires a partnership of dialogue throughout the process of your treatments. All treatments you receive at Sacred Winds will comply with state licensing laws.

I understand that I am an active participant in my therapy and that it is my responsibility to provide accurate and timely feedback to the therapist about my response to any technique/session. I am responsible for keeping my therapist updated on any change(s) in my healthcare status (new injury, change in medication, etc.)

I understand that I am in full control of my treatment. I understand that I have the right to cease any technique/session by asking my therapist to HALT (in place of stop) and that my request will be respected without question. The therapist may also stop treatment during a session if the need arises.

I understand that payment is expected in full following each session, with the exception of Intensives that will be paid in full at the time of scheduling.

After Care: *It is recommended to drink plenty of water and take Epsom Salt baths after every session to reduce discomfort from the changes that are naturally occurring in your body and to enhance the treatment.*

By signing below, I acknowledge that I have read and understood the statements above.

Patient Name_____

Patient Signature_____

Date_____

Sacred Winds Center for Healing
Cancellation Policy

All treatments are by appointment only. Appointments are scheduled in advance depending on time and availability, of the therapist. Patients are expected to arrive on time for all scheduled appointments.

Please arrive 5 -10 minutes earlier than your scheduled block of time. We ask that patients call the therapist if they anticipate arriving late.

Please note that in cases of tardiness and depending on therapist availability, a patient may be given the option to be treated in the allowable remaining time, with the understanding that they are still responsible for full payment for the originally scheduled block of time. Patients can also choose to cancel and will be charged for a full session.

Your treatment is provided during a specific block of time that is reserved for you. Cancellations with less than 24 hours prior notice will result in a **full fee** charge per scheduled hour. The cancellation fee is to be paid in full prior to any future scheduling.

For Intensive Treatments:
Payment in full is required which reserves appointment times for an intensive treatment series. This payment will be non-refundable should the patient cancel his/her intensive treatments. Arrangements for rescheduling is possible upon availability of the therapist.

I understand and I agree that I am accountable to the cancellation policy above.

Printed Name_____ Date_____

Patient Signature _____

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Sacred Winds
CENTER FOR HEALING

CLIENT INTAKE FORM

Sacred Winds Center for Healing Pain and Chronic Pain

NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

EMAIL:_____

ADDRESS:_____

DOB:____/____/____ **DATE:**____/____/____ **AGE:**_____

MALE/FEMALE

OCCUPATION:_____**PHONE: Work (**____**)**_____

EMPLOYER:_____**Home (**____**)**_____

What is your primary condition?_____

_____

Do you have any other significant health concerns?_____

_____

When did you first notice these symptoms?_____

_____

Have you experienced something similar before? Yes___ No___

Explain:_____

_____

Have you seen a doctor for this condition? Yes___ No___

If yes, what is the doctor/professional's name_____

Do I have your permission to contact him/her should the need arise?

Yes___ No___

What is your work/hobby?_____

Are you working? Yes___ No___

If no, is it due to your current condition? Yes___ No___

Just prior to this onset, were you completely free of symptoms?

Yes___ No___

Describe the nature of your condition:_____

_____

What, if any, treatments have you had for this current condition?

_____

What aggravates your symptoms?_____

_____

What, if anything, eases your pain?_____

Can you get comfortable at night? Yes___ No___

How did you feel upon rising? Stiff___ Sore___ Fine___

Once you start moving about, does the pain get: Better___or Worse___?

What is the pain like at the end of the day? Better___ or Worse___?

Are you taking any medications? Yes___ No___ List medications:

_____

At this time, are you feeling: Better___ Worse___ Same___

CHECK ANY of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Surgery (list)

_____

_____

_____

_____

_____

_____

- ☐ Thyroid Disorders
- ☐ Major Trauma (Car, fall, etc.-list)

_____

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_____

_____

- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (Specify)

_____

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CHECK ANY conditions or usage that apply to you.

- ☐ Poor appetite
- ☐ Low appetite
- ☐ Heavy appetite
- ☐ Coffee
- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Recent weight loss/gain
- ☐ Poor sleep
- ☐ Dream-disturbed sleep
- ☐ Glasses
- ☐ Eye pain
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Soft drinks
- ☐ Artificial sweetener
- ☐ Drugs
- ☐ Stress
- ☐ Occupational hazards
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of breath
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sinus problems
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Sugar
- ☐ Salty food
- ☐ Regular exercise:

Type_____

_____

_____

- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Vertigo or dizziness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Pour hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Thirsty for water:

Glasses per day:_____

Frequency_____

_____

- ☐ Bleed or bruise easily
- ☐ Peculiar taste (describe)

_____

_____

_____

_____

_____

- ☐ Other head or neck problems

_____

_____

_____

_____

_____

_____

_____

_____

_____

- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Rashes
- ☐ Hives

- ☐ Fungal infections
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Pain on urination
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Irregular periods
- ☐ Length of cycle (day 1 to day 1)

_____

- ☐ Date last period began

_____

- ☐ Painful periods
- ☐ PMS
- ☐ Breast lumps
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse Survivor
- ☐ Considered/attempted suicide
- ☐ Seeing a therapist

- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emissions

Pregnancies:

_____

Live births:

_____

Premature births:

_____

Age at menopause:

_____

- ☐ Date of last PAP

_____

_____

Other:_____

_____

_____

_____

_____

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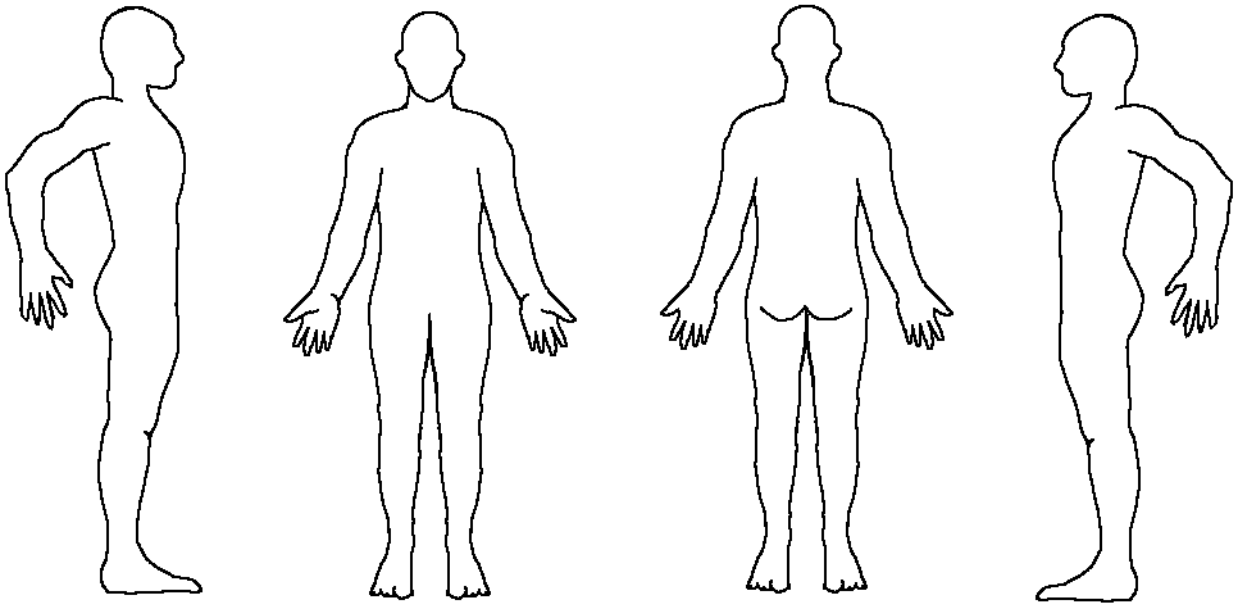
_____

CLIENT ANATOMICAL REPORT

NAME: _____ DATE: _____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagram below.

Key	
	Circle areas where pain exists
	Circle areas with small dots where extreme pain exists
	Put an “X” over stiff areas
	Draw squiggly lines over areas of numbness or tingling
	Mark scars, bruises or wounds



Rate your pain on a scale of 1-10 with 1 being “no pain” and 10 being the worst pain you could possibly imagine: _____

Comments: _____

_____

_____

_____