Welcome

The Breath S P A C E

Please help *me* help *you* by sharing your history and goals.

Thank you for your interest in The Breath S P A C E. The sole aim of my work focuses on restoring balance, living in peace and accepting the present moment. Rather than treating pathology or disease, I examine the state of the nervous system as an indicator of your current level of stress or balance. I see myself more of a coach and a guide, helping you discover more about yourself - how you inhabit your mind-body, how you listen to your soul and spirit, how you orient to the world, how you learn to soothe and settle, and, in essence how you *breathe into your life.*

To begin this journey, I would like to gain a more holistic understanding of you as an individual and your health care needs. The following questions focus on assessing your: goals for care, medical and physical history, functional ability, nutritional status, behavioral and lifestyle factors, psycho-emotional/mind-body state and global health. Answer the questions to the best of your ability, clarifying and elaborating whenever you can. Thank you for the opportunity to allow me to help you with your health care needs!

The Breath S P A C E
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Personal Information

Please provide the following information and answer the questions below.
Note: *all information provided is protected as confidential information.*

Name _____ Date of Birth: _____
(Last) (First) (Middle Initial)

Social Security Number: _____

Gender Identification: Male Female Other *please specify* _____

Personal Pronouns Preferred He She Other *please specify* _____

Address:

_____
(Number and Street) (City) (State) (Zip)

Home Phone: ( ) *May we leave a message?* Yes No

Mobile (Other): ( ) *May we leave a message?* Yes No

May we text you? Yes No

Email _____ *May we leave a message?* Yes No

* *Email correspondences are not considered confidential communications.*

Name of Parent / Guardian (*if younger than 18 years of age*):

_____
(Last) (First) (Middle Initial)

Emergency Contact

_____
(Last) (First) (Middle Initial)

Relationship To You _____

Relationship Status:
Single Domestic Partnership Married Separated Divorced Widowed

Name of Partner/Spouse: _____

Name and Age of Any Children

_____

Nearest Relative _____ Phone _____

How Did You Hear About My Practice _____

Referred By _____

Personal Wellness Goals

On the Continuum Below, Indicate with a Check Mark Your Current State of Well-Being?
Excellent _____ Poor

What are Your Current Health and Wellness Goals?

1. Physical health:
   _____
   _____
   _____

2. Emotional health:
   _____
   _____
   _____

3. Mental health:
   _____
   _____
   _____

4. Spiritual health:
   _____
   _____
   _____

How will you Know When you have Achieved Your Goals? What will Your Life Look Like? What will Be Different?

_____
_____
_____

What is Your Life Purpose? Do You Have a Personal Mission Statement for Your Life? If So, What Is It?

_____
_____
_____
_____

Where Would You Like to see Your Life / Yourself / Your Health Six Months from Now?

_____
_____
_____
_____

Where Would You Like to See Your Life / Yourself / Your Health One Year from Now?

_____
_____
_____
_____

The focus of our work is restoring balance and breathing more fully into life. That said, it is useful to clearly identify how you are assessing change. While not treating symptoms directly, they can be guides and indicators of change. For that reason, select one or two symptoms (physical, emotional, or mental) which bother you the most. Identify them and write them down. Now scale the severity or intensity of each symptom over the last week, and score it by circling your chosen number.

SYMPTOM 1: _____

0 1 2 3 4 5 6
as good as it could be *as bad as it could be*

SYMPTOM 2: _____

0 1 2 3 4 5 6
as good as it could be *as bad as it could be*

Now choose one activity (physical, social or mental) that is important to you, and that your *problem* makes difficult or prevents you doing. Score how it has been in the last week.

ACTIVITY: _____

0 1 2 3 4 5 6
as good as it could be *as bad as it could be*

Lastly how would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6
as good as it could be *as bad as it could be*

How long have you had Symptom 1, either all the time or on and off? PLEASE CIRCLE

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years

Are you taking any medication for this problem? __ YES __ NO
IF YES:
Please write in name of medication, and how much a day/week _____
_____
_____

Is cutting down this medication: *Please circle:*

not important *a bit important* *very important* *not applicable*

IF NO:
Is avoiding medication for this problem: *Please circle:*
not important *a bit important* *very important* *not applicable*

What, if Anything, Keeps you from Being Your Most Authentic, Vital Self? What Might be Limiting You, Holding You Back or Preventing You from Your Authenticity and Vitality?

What Do You Love and Celebrate about Yourself? What Do You Appreciate about Your Life?

What is Missing from Your Life?

What are Your Creative Outlets?

Have There Ever Been Any Life Experiences / Situations Which Did, or Continue To, Affect You Deeply?

Do You Have Any Opinions or Ideas Regarding What Has Caused Your Present Health Conditions?

How Would You Describe Your Current Stress Level, and What Do You Do To Relax?

Is there Any Other Information You Think is Important or that You Would Wish to Share?

Two Wishes

Imagine You Find a Magic Genie Lamp and You Are Granted Two Wishes:
Wish Number 1:
In Six Months from Now, Your Life Can be Anything You Wish, without Limitations. Where and How Do You Want to Live?

Recently in Your Life, What Efforts Have You Made to Shape Your Life so That it More Resembles This?

What in You Makes it Hardest to Move Toward This?

Wish Number 2:
In Six Month's Time You Can Personally Transform. How would Like Your Psyche, Your Personality, Your Feelings, Your Mind to Change, Grow, and Develop so that Your Life will be as Full and Rich as Possible? What New Gifts and Abilities Would you like to Possess? What Aspects of your Pysche Would you Like to Diminish or Disappear?

Recently in Your Life, What Efforts Have You Made to Move and Change in this Direction?

What in You Makes it Hardest to Move and Change In this Direction?

If Your Symptoms / Body Could Talk to You, What Would They / It Like You To Know?

Quality of Life

1. In general, would you say your health is? Circle: *Excellent* *Very Good* *Good* *Fair* *Poor*

2. During the **past 4 weeks,** how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
   a. Accomplished less then you would like? Circle:
      All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*
   b. Were limited in the kind of work or other activities? Circle:
      All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

3. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during **the past 4 weeks:**
   a. Have you felt calm and peaceful? Circle:
      All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*
   b. Did you have a lot of energy? Circle:
      All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*
   c. Have you felt downhearted and depressed? Circle:
      All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

4. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (life visiting friends, relatives, etc.)? Circle:
   All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

Emotional Health

How often do you feel stress at home (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at home)?

Never *Some periods* *Several periods* *Permanent*

How often do you feel stress at work (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at work)?

Never *Some periods* *Several periods* *Permanent*

How would you describe your financial stress?

Little or none *Moderate* *High/severe* *None of the time*

Have you had any of the major traumatic life events within the past year: marital separation or divorce, loss of job or retirement, loss of crop or business failure, death or major illness of a close family member, death of a spouse, or other major stress?

__ Yes __ No

If Yes, Please Describe

_____

_____

_____

_____

Using the following scale, please circle the number representing how much you agree or disagree with the following statements:

0=Don't agree at all 3=Neither agree or disagree 6=Strongly agree

a. At home, I feel I have control over what happens in most situations	0	1	2	3	4	5	6
b. I feel that what happens in my life is often in my control	0	1	2	3	4	5	6
c. Over the next 5±10 years I expect to have many more positive than negative experiences:	0	1	2	3	4	5	6
d. I often have the feeling that I am being treated unfairly:	0	1	2	3	4	5	6
e. In the past 10 years my life has been full of changes without my knowing what will happen next:	0	1	2	3	4	5	6
f. I gave up trying to make big improvements or changes in my life a long time ago:	0	1	2	3	4	5	6
g. Keeping healthy depends on things that I can do:	0	1	2	3	4	5	6
h. There are certain things I can do for myself to reduce the risk of a heart attack:	0	1	2	3	4	5	6
i. There are certain things I can do for myself to reduce the risk of getting cancer:	0	1	2	3	4	5	6

Have you felt sad, depressed or "blue" for two weeks or more in a row over the past 12 months?

__Yes __ No

If Yes, have you:

Lost interest in things?	Yes	No
Felt tired or low on energy?	Yes	No
Gained or lost weight?	Yes	No
Had trouble falling asleep?	Yes	No
Had trouble concentrating?	Yes	No
Thought of death?	Yes	No
Felt worthless?	Yes	No

Please rate how often you have been bothered by any of the following problems over the last 2 weeks using the following scale:

0=Not at All 1=Several Day 2=More than half the days 3=Nearly every day DK=Don't know

a. Little interest or pleasure in doing things.	0	1	2	3	DK
b. Feeling down, depressed, or hopeless.	0	1	2	3	DK
c. Trouble falling or staying asleep OR sleeping too much.	0	1	2	3	DK
d. Feeling tired or having little energy.	0	1	2	3	DK
e. Poor appetite OR overeating	0	1	2	3	DK
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3	DK
g. Trouble concentrating on things, such as reading a newspaper or watching television.	0	1	2	3	DK
h. Moving or speaking so slowly that other people could have noticed OR—the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3	DK

Relationship / Family Dynamics

Are you in a Romantic Relationship? If so, Are you Happy and Fulfilled? In What Ways are You Fulfilled? If not, Do you Wish You Were?

How Would You Describe Your Support System? How do you Access Your Support?

How Would You Describe Your Family Relationships? In What Ways are You Similar to Your Parents / Grandparents / Siblings (+ and -)? In What Ways are You Different?
What Patterns / Traits Have You Consciously or Unconsciously Adopted You Consider Strengths?
What Patterns / Traits Have You Consciously or Unconsciously Adopted You Would Like to Surrender?

Healthcare

Current Primary Care Provider _____
Last Seen _____ Last Complete Screening _____
For What _____
_____

Have You Had, or Do You Continue to Partake in the Following Towards Healing or Wellness? If so, Please List When and Any Comments You Wish to Make:

Yes	No	
Yes	No	Acupuncture
Yes	No	Biofeedback / EEG Neurofeedback
Yes	No	Bodywork/Massage
Yes	No	Chiropractic
Yes	No	Exercise
Yes	No	Herbal / Botanical Medicine (*which ones?)*
Yes	No	Homeopathic Medicine (*which ones?)*
Yes	No	Meditation
Yes	No	Movement Therapy
Yes	No	Nutritional Supplements / Dietary Changes
Yes	No	Osteopathy/Cranio-Sacral Therapy
Yes	No	Physical Therapy
Yes	No	Psychotherapy / Counseling
Yes	No	Yoga
Yes	No	Other (s) _____

List Other Health Care Practitioners You Currently Consult:
Name _____ When Consulted _____
For What? _____ Treatment _____
_____
How Long have You Seen this Practitioner? _____ How Often? _____
Results _____

Name _____ When Consulted _____
For What? _____ Treatment _____
_____
How Long have You Seen this Practitioner? _____ How Often? _____
Results _____

List Any Prior Surgeries, Hospitalizations, and Major Injuries and Dates
Type/When/Doctor/Outcome
_____
_____
_____

List any current or past allergies you have
_____
_____
_____

List your current medications, who prescribed each, current dosage, and how often you take them, the benefits of taking them, and any side effects. Please include:
Prescription medications
Over the counter medications
Vitamins
Herbal supplements (East Asian and Western)
Homeopathic Remedies

Medication Dosage Frequency Benefits Side Effects

List of any medications that you don't tolerate well or have had a bad reaction to in the past

Do you have any of the following concerns with your medications/supplements? (Circle all that apply.)
Costs too much
Run out often
Do not think I need it
Take differently than prescribed
Problems with side effects. Explain: _____

Have you smoked more then ten cigarettes in your life?		
(If yes, how long ago? ____ years)	Yes	No
Do you smoke currently?	Yes	No
Do you get at least 150 minutes of physical activity per week?	Yes	No
Do you eat at least 5-7 servings of fruits/vegetables per day?	Yes	No
Do you eat fish at least 2x per week, or take a fish oil supplement?	Yes	No
Do you consume alcohol? (If yes, # drinks/week? _____)	Yes	No
Do you consume more than 5 8oz glasses of water a day?	Yes	No

Please List The Ages And Health Concerns Of All Living Relatives. If Deceased, Please List At What Age They Died And, If Known, The Cause:

Mother _____
Father _____
Brother(s)/Sister(s) _____
Grandparents _____

Work / School History

Describe Your Current Work / School Situation (Where, What, Number of Hours)

_____

_____

How Would You Rate / Describe Your Stress Level at Work / School?

_____

_____

_____

Do You Enjoy Your Work / School? Are You Fulfilled at Work?
If Yes, How Does it Fulfill You? If No, For What Purpose do You Stay at this Job?

_____

_____

_____

_____

What Would You Rather Be Doing with Your Life? What Prevents You

_____

_____

_____

Describe Your Physical Work / School Situation: Seated / Standing / Work Bench / Desk / Counter / Other?
Lifting / Bending / Stooping / Twisting / Walking / Other

_____

_____

Types of Shoe Worn _____
Type of Chair _____

Physical Activity

Do You Like Your Body? If No, In What Ways are You Dissatisfied With It and Why?

_____

_____

_____

Are You Physically Active / Do You Exercise? If So, What Type(s)?

_____

_____

What is Your Typical Physical Activity Schedule?

Monday _____ Thursday _____
Tuesday _____ Friday _____
Wednesday _____ Saturday _____
Thursday _____ Sunday _____

For What Reason(s) Do You Exercise?

_____

_____

Are You Happy with Your Level of Physical Activity, and If No, Where Would You Like it to Be?

_____
_____
_____
_____

Do You Enjoy Physical Activity? Do You Enjoy Exercise?

_____
_____

What Do You Like Most about Exercising?

_____
_____

What Do You Like Least about Exercising?

_____
_____

Have You Ever Discontinued Strenuous Exercise/Sports and Why?

_____
_____

What Fears, If Any, Do You Have About Physical Activity?

_____
_____

What Would Be Your Ideal Setting in which to Exercise? Why?

_____
_____

Sleep History

Number of Hours of Sleep per Night During Weekdays ___Do You Wake Refreshed Y N
Number of Hours of Sleep per Night During Weekends ___Do You Wake Refreshed Y N
Ideal Number of Hours You Would Like to Sleep/Night? ___Do You Fall Asleep During Day? Y N
Do You Have Difficulty Falling Asleep at Night? Y N How Long Does it Take to Fall Asleep _____
Do You Wake in the Middle of the Night? Y N Can You Return to Sleep/How Long? _____
What Wakes You? _____ Are You a Heavy or Light Sleeper? _____
Do You Have Nightmares (Frequency/Type)? _____
Please List Any Recurring Dreams or Themes to Your Dreams, Either in the Past or Currently (Frequency or Type)? _____
_____
_____
Do You Sleep with Windows Open or Closed, Why? _____
Do You Talk/Grind Teeth/Drool/Sleepwalk/ Have Leg Cramps or Restless Legs at Night? _____
_____
What is Your Preferred Position in Which to Sleep, and Why? _____
When You Sleep, Do you Ever Uncover Any Body Parts, and Which? _____
What is Your Best Time of Day (Physically, Emotionally or Mentally)? _____
What is Your Worst Time of Day? _____

Diet & Nutrition

Please Circle Appropriate Answer and Complete

Consume Alcohol?	Y N	What/How Often/Socially or Alone _____
Smoke	Y N	How Long/How Many / Day _____
Past History	Y N	When and How Long _____
Caffeine Intake	Y N	In What Form/How Often/Craving _____
Sugar Intake	Y N	Form/How Often/Craving _____
Use Saccharine or NutraSweet	Y N	What Form/How Much per Day _____
Fast Food Intake	Y N	How Often/Where _____
Carbonated Drinks?	Y N	How Often/Which Ones _____
Drink Water?	Y N	How Many Glasses per Day/Sources _____
Eat Fried Foods?	Y N	How Often/Where/What _____
Eat Margarine?	Y N	How Much per Day _____
Eat Meat	Y N	How Often per Week _____
Eat Poultry	Y N	How Often per Week _____
Eat Fish	Y N	How Often per Week _____
Dietary Restrictions?	Y N	What/How Long _____

Do You Have Any Consistent Food Cravings, Foods You Just Need to Eat or Those That You Find You Eat on a Regular Basis (If not a specific food, any particular flavors or tastes)? _____

_____

_____

What Foods Do You Dislike or Avoid Because You Do Not Like the Taste? _____

_____

Are There Any Foods That You React to on Any Level? _____

_____

What is Your Thirst Like? Do You Sip or Gulp? And What Temperature of Beverages Do You Prefer, and Why? _____

What Does Food Mean to You? _____

_____

Are You Satisfied with Your Diet? __ Y __ N In What Way Would You Like Your Diet to Change?

_____

_____

How is Your Current Diet Serving You? (What is the Pay-off For Your Current Way of Eating? Our Behaviors Always Serve Us Somehow.) _____

_____

What Would it Require/What Would You Need to Change Your Diet? _____

_____

In Your Opinion, What Would a Health Diet Look Like? _____

_____

_____

Four-Day Diet Diary

Write Down Everything You Ingest for Four Days. Include Supplements and Fluids.

Yesterday's Food Intake Log	
Meal 1 Time :	
Meal 2 Time :	
Meal 3 Time :	
Meal 4 Time :	
Meal 5 Time :	
Meal 6 Time :	

Today's Food Intake Log	
Meal 1 Time :	
Meal 2 Time :	
Meal 3 Time :	
Meal 4 Time :	
Meal 5 Time :	
Meal 6 Time :	

Write Down Everything You Ingest for Four Days. Include Supplements and Fluids

Yesterday's Food Intake Log	
Meal 1 Time :	
Meal 2 Time :	
Meal 3 Time :	
Meal 4 Time :	
Meal 5 Time :	
Meal 6 Time :	

Today's Food Intake Log	
Meal 1 Time :	
Meal 2 Time :	
Meal 3 Time :	
Meal 4 Time :	
Meal 5 Time :	
Meal 6 Time :	

Instructions: Circle the Y if You Currently Experience the Symptom, N if You Never Experienced the Symptom, and P if you have Experienced the Symptom in the Past

Part I
Head/Neurological

1.	Head feels heavy	Y	N	P
2.	Light headedness/fainting	Y	N	P
3.	Loss of balance	Y	N	P
4.	Dizziness	Y	N	P
5.	Ringing in ears	Y	N	P
6.	Trembling in hands or feet	Y	N	P
7.	Loss of feeling in hands or feet	Y	N	P
8.	Double Vision	Y	N	P
9.	Headaches	Y	N	P
10.	Night Blindness	Y	N	P
11.	Eye Pain/Itching	Y	N	P
12.	Halos or Lights in Eyes	Y	N	P
13.	Blurry Vision	Y	N	P
14.	Glaucoma	Y	N	P
15.	Cataracts	Y	N	P
16.	Light Sensitivity	Y	N	P
17.	Swollen Eyes	Y	N	P
18.	Circles Under Eyes	Y	N	P
19.	Poor Concentration	Y	N	P
20.	Mood Swings	Y	N	P
21.	Slurred Speech	Y	N	P

Part II
Respiratory

1.	Difficulty Breathing	Y	N	P
2.	Chronic Cough	Y	N	P
3.	Coughing Phlegm/Blood	Y	N	P
4.	Asthma	Y	N	P
5.	Allergies	Y	N	P
6.	Bronchitis	Y	N	P
7.	Pneumonia	Y	N	P
8.	Tuberculosis	Y	N	P
9.	Frequent Chest Colds	Y	N	P
10.	Exposed to Chemicals	Y	N	P

Part III
Genito-Urinary

1.	Frequent Urination	Y	N	P
2.	Wake to Urinate	Y	N	P
3.	Pain on Urination	Y	N	P
4.	Brown, Black or Bloody Urine	Y	N	P
5.	Bladder Infections	Y	N	P
6.	Constant Urge to Urinate	Y	N	P
7.	Unable to Urinate	Y	N	P
8.	Bed Wetting	Y	N	P
9.	Prostatitis	Y	N	P
10.	Urination on Laughing/ Sneezing/Crying	Y	N	P
11.	Kidney Infections/Stones	Y	N	P

Part IV
Sinus/Ear/Nose/Throat

1.	Frequent colds	Y	N	P
2.	Sore Throats	Y	N	P
3.	Sore or Bleeding Gums	Y	N	P
4.	Nose Pain	Y	N	P
5.	Nose Bleeding	Y	N	P
6.	Nose Discharge	Y	N	P
7.	Frequent Blowing Nose	Y	N	P
8.	Difficulty Nose Breathing	Y	N	P
9.	Earaches	Y	N	P
10.	Canker Sores	Y	N	P
11.	Dental Problems	Y	N	P
12.	Difficulty Speaking	Y	N	P
13.	Difficulty Swallowing	Y	N	P
14.	Hayfever	Y	N	P
15.	Post Nasal Drip	Y	N	P
16.	Loss of Taste	Y	N	P

Part V
Skin

1.	Rashes	Y	N	P
2.	Hives	Y	N	P
3.	Dryness	Y	N	P
4.	Itching	Y	N	P
5.	Bruise Easily	Y	N	P
6.	Loss of Hair	Y	N	P
7.	Ulcerations/Sores	Y	N	P
8.	Growths	Y	N	P
9.	Acne	Y	N	P
10.	Shingles	Y	N	P
11.	Thick Skin or Finger Nails	Y	N	P
12.	Swollen/Wrinkling/Puffy Skin	Y	N	P

Part VI
Cardio-Vascular

1.	High Blood Pressure	Y	N	P
2.	Low Blood Pressure	Y	N	P
3.	Rapid Beating Heart	Y	N	P
4.	Slow Beating Heart	Y	N	P
5.	Pain Over the Heart	Y	N	P
6.	Swelling of the Ankles	Y	N	P
7.	Poor Circulation	Y	N	P
8.	Varicose Vein	Y	N	P
9.	Stroke	Y	N	P
10.	Heart Attack	Y	N	P
11.	Chest Pain	Y	N	P
12.	Pain in Left Arm	Y	N	P
13.	Poor Wound Healing	Y	N	P
14.	Cold Hands and Feet	Y	N	P

Part VII
Emotional

1.	Depression	Y	N	P
2.	Nervousness/Anxiety	Y	N	P
3.	Stressed	Y	N	P
4.	Mood Swings	Y	N	P
5.	History of Trauma/Abuse	Y	N	P
6.	Poor Memory	Y	N	P

Part VIII
Musculo-Skeletal

1.	Back Aches	Y	N	P
2.	Leg Cramp on Walking	Y	N	P
3.	Weakness in Arms/Legs	Y	N	P
4.	Numbness	Y	N	P
5.	Joint Pain or Stiffness	Y	N	P
6.	Muscle Cramps or Stiffness	Y	N	P
7.	Morning Pain or Stiffness	Y	N	P
8.	Sciatica	Y	N	P
9.	Swelling of Hands and Feet	Y	N	P
10.	Neck Pain	Y	N	P
11.	Difficulty Standing or Sitting	Y	N	P
12.	Tremors	Y	N	P
13.	Foot Trouble	Y	N	P
14.	Gout	Y	N	P
15.	Sprained Ankle	Y	N	P
16.	Broken Bones	Y	N	P

Part IX
Gastro-Intestinal

1.	Chronic Nausea	Y	N	P
2.	Vomiting	Y	N	P
3.	Vomiting Blood	Y	N	P
4.	Food Allergies/Sensitivities	Y	N	P
5.	Difficulty Chewing	Y	N	P
6.	Swallowing	Y	N	P
7.	Belching Gas	Y	N	P
8.	Gastritis/Heartburn	Y	N	P
9.	Pain over Stomach	Y	N	P
10.	Ulcers/Stomach Disorders	Y	N	P
11.	Distention of Abdomen	Y	N	P
12.	Constipation	Y	N	P
13.	Diarrhea	Y	N	P
14.	Colitis	Y	N	P
15.	Diverticulosis	Y	N	P
16.	Hemorrhoids	Y	N	P
17.	Liver Trouble	Y	N	P
18.	Gallbladder Trouble	Y	N	P
19.	Jaundice	Y	N	P
20.	Black Stools	Y	N	P
21.	Bloody Stools	Y	N	P
22.	Floating Stools	Y	N	P
23.	Bowel Movement per Day	_____		
24.	Hiatal Hernia	Y	N	P

Part X
Endocrine

1.	Cold Hands and Feet	Y	N	P
2.	Excessive Hunger	Y	N	P
3.	Excessive Thirst	Y	N	P
4.	Excessive Sweating	Y	N	P
5.	Poor Appetite	Y	N	P
6.	Chronic Fatigue	Y	N	P
7.	Recurrent Fevers	Y	N	P
8.	Chills	Y	N	P
9.	Diabetes	Y	N	P
10.	Rheumatic Fever	Y	N	P
11.	Loss of Weight	Y	N	P
12.	Weight Gain	Y	N	P
13.	Cancer	Y	N	P
14.	Heat Intolerance	Y	N	P

Part XI
Female

1.	Premenstrual Tension	Y	N	P
2.	Lumps in Breast	Y	N	P
3.	Pelvic Pain	Y	N	P
4.	Menstrual Pain	Y	N	P
5.	Excessive Flow	Y	N	P
6.	Irregular Cycle	Y	N	P
7.	Infertility	Y	N	P
8.	Hot Flashes	Y	N	P
9.	Menopausal Symptoms	Y	N	P
10.	Vaginal Discharge	Y	N	P
11.	Hysterectomy	Y	N	P
12.	Family History of Cancer	Y	N	P
13.	Are You Pregnant	Y		
14.	Number of Pregnancies	_____		
15.	Termination of Pregnancy	Y ___	N ___	
16.	Number of Live Births	_____		
17.	Date of Last Period	_____		
18.	Sexually Active	Y	N	P
19.	Sexually Transmitted Diseases	Y	N	P
20.	Sexual Orientation	_____		

Part XII
Male

1.	Penile Pain	Y	N	P
2.	Scrotal Pain	Y	N	P
3.	Inflammation of Scrotum	Y	N	P
4.	Erectile Difficulty	Y	N	P
5.	Impotence	Y	N	P
6.	Penile Discharge	Y	N	P
7.	Hernia	Y	N	P
8.	Sexually Active	Y	N	P
9.	Sexually Transmitted Diseases	Y	N	P
10.	Sexual Orientation	_____		

DISCLOSURE STATEMENT & POLICY

About My Practice

- I am a licensed naturopathic physician and board certified biofeedback specialist
- I am full time Associate & Clinical Faculty at Bastyr University where I teach Behavioral & Mindbody Medicine courses and Supervise the Clinical Mind-body Medicine Shifts - therefore I am only available in private practice ~ 2 days a week, and these days may change per quarter. Evening appointments are available on occasion.
- Appointment length: typically 50 minutes, unless patients request longer sessions
- I do offer phone, Skype and FaceTime sessions as well

Payment & Insurance

- Payment is due at the time of visit (check or cash, for Visa and MC there is a 4% processing fee)
- I am not contracted with any insurance companies
- I can, however, provide an Invoice so that you can submit a claim to your insurance carrier directly for reimbursement, if they cover out of network providers
- All sessions are billed as Naturopathic Medicine
- Rates: $150 per 50 minutes, yet I offer sliding scale based on financial need

Cancellation Policy

- Cancellation policy: > 24-hour without charge, < 24-hours then 50% of visit charge

Location

- 11 W McGraw Street, Seattle WA 98119
- The office is a large gray house with both outside and inside stairs (please let me know if this will be an issue for you). The house is on the north side of the McGraw, just past the Pizza Hut on the corner of Queen Anne and McGraw (there is a large hedge separating Pizza Hut and our office, thankfully). Once you enter the house, you are in the waiting room area. I will come down to get you for our session.
- There is a good deal of free street parking in the area

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Patient Name: _____ Date: _____
Patient Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

By signing below, I authorize Dr. Brad Lichtenstein & The Breath S P A C E to maintain a copy of my credit card information on file in case I incur any outstanding balances. This information will not be shared with any third parties and will be kept confidential. You will be immediately informed of any balances or charges before they are applied to your card.

I, _____, hereby authorize Dr. Brad Lichtenstein & The Breath S P A C E, to utilize my credit card on file for any outstanding balances.

Credit Card Type Visa Mastercard American Express

_____ _____ _____ _____
Credit Card Number *CVV (3 digit on back of card)* *Exp Date* *Billing Zip Code*

_____ _____
Authorization Signature *Date*