INTEGRATIVE BODYWORK, INC

NEW CLIENT INFORMATION

DATE _____

CLIENT NAME LAST _____ FIRST _____ MI _____

EMAIL _____ PRIMARY PHONE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BEST TIME AND PLACE TO REACH YOU _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX - M_____ F_____ AGE _____ BIRTH DATE _____ MINOR _____

MARRIED_____ WIDOWED_____ SINGLE_____ SEPARATED_____ DIVORCED_____ PARTNERED_____

OCCUPATION _____

CLIENT EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY, CONTACT

NAME _____ RELATIONSHIP _____ PRIMARY PHONE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ NAME OF INSURED _____

EMPLOYER _____ MEMBER ID _____

ADDRESS _____ GROUP # _____

CITY _____ STATE ____ ZIP _____ PHONE _____

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CLIENT CONDITION

Reason for visit_____

When did your symptoms first appear?_____

Are your symptoms due to:

___ Accident ___ Trauma ___ Injury ___ Accumulated Stress

_____

Were there any lasting physical or emotional effects after the accident/trauma/stressful event such as:

___ Tension ___ Pain ___ Numbness ___ Shallow Breathing

___ Fearful Thoughts ___ Sleep Difficulty ___ Digestive Problems ___ Other

_____

Were you under any additional stress at the time of the accident/trauma/stressful event with:

___ Family ___ Work ___ Finances

_____

Exactly where is your pain most severe?

_____

Is this condition getting progressively worse?

_____

Has the location and/or intensity changed?

_____

Does any position, stretch or movement give you relief?

_____

Are heat or cold packs helpful?

_____

Do you have problems sleeping?

___ Going to sleep ___ Staying asleep

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Yes No

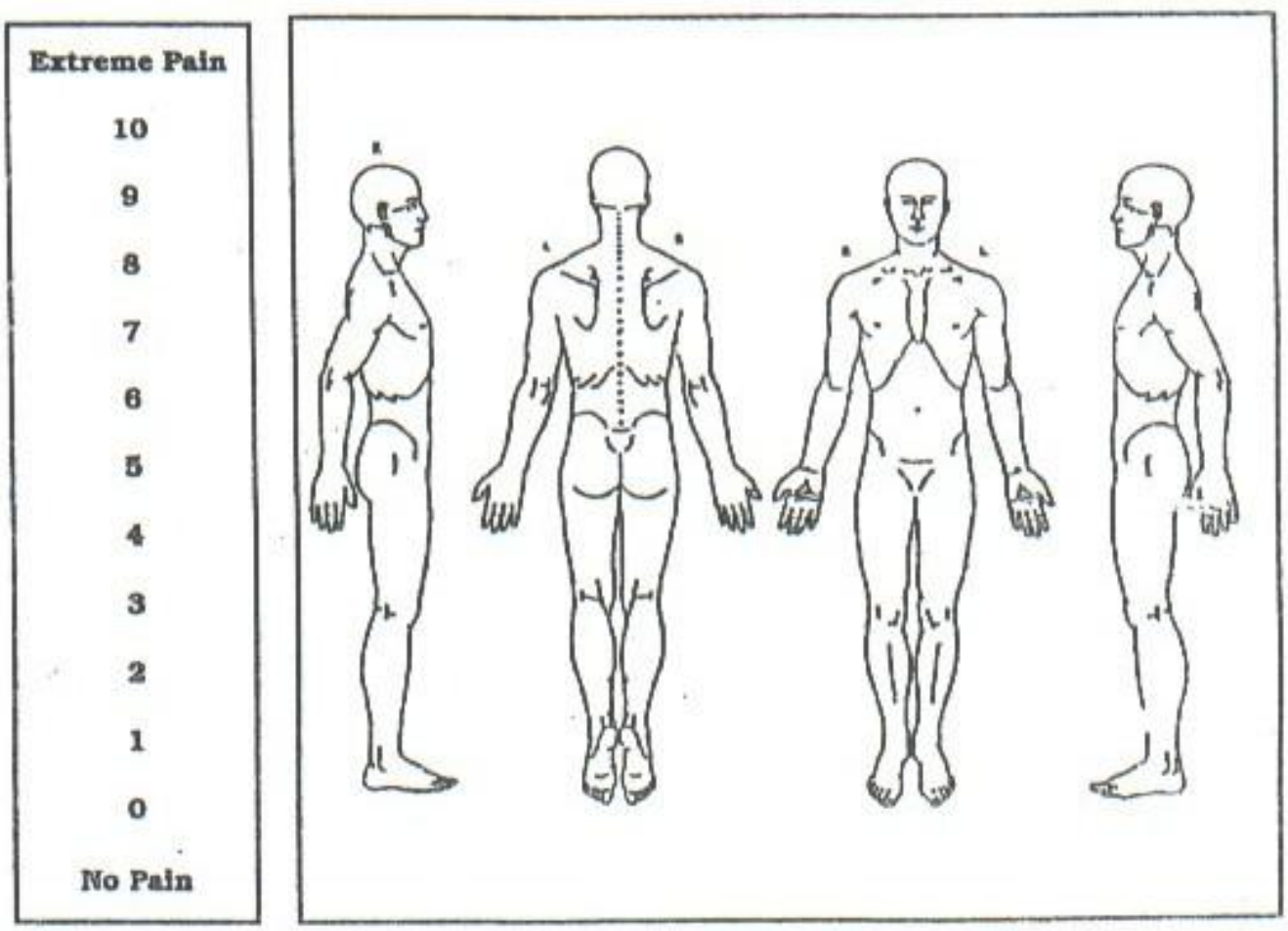
_____ _____ Do you associate any of your pain with stressful situations in your life?

_____ _____ Do you associate any of your pain with the way you think about things ~ your thought processes?

_____ _____ Do you associate any of your pain with how you process your feelings or emotions? For example, holding in your feelings?

Mark on the picture below where you continue to have pain, numbing or tingling and rate the severity of your pain according to the scale below where 1 is least pain and 10 is severe pain.

For example – if you have severe pain in the back of your neck (2nd figure) place a "10" in that box.



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TYPE OF PAIN

___ Sharp	___ Dull	___ Throbbing	___ Numbness
___ Aching	___ Shooting	___ Burning	___ Tingling
___ Cramps	___ Stiffness	___ Swelling	___ Other

How often do you have this pain?_____ Is it constant or does it come and go?_____

Is this condition getting progressively worse? ___Yes ___No ___Unknown

Does it interfere with your ___Work ___Sleep ___Daily Routine ___Recreation

Activities/movements that is painful to perform ___Sitting ___Standing ___Walking ___Bending ___Lying Down

What treatment have you already received for your condition?

___Medications ___Surgery ___Physical Therapy ___Chiropractic ___None ___Other _____

Name and Address of other Doctor(s), Therapist(s), Healer(s) who have treated you for your condition

_____

_____

DATE OF LAST

Physical Exam_____ Blood Test_____ Urine Test_____

MRI, CT-Scan, Bone Scan_____

ARE YOU PREGNANT? ___Yes ___No Due Date_____

INJURIES/SURGERIES YOU HAVE HAD	**DESCRIPTION**	**DATE**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

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HEALTH HISTORY

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	AIDS/HIV	___	___	Diabetes	___	___	Measles	___	___	Rheumatic Fever
___	___	Alcoholism	___	___	Emphysema	___	___	Migraines	___	___	Scarlet Fever
___	___	Allergy Shots	___	___	Epilepsy	___	___	Miscarriage	___	___	Stroke
___	___	Anemia	___	___	Fractures	___	___	Mononucleosis	___	___	Suicide Attempt
___	___	Anorexia	___	___	Glaucoma	___	___	Multiple Sclerosis	___	___	Thyroid Problems
___	___	Appendicitis	___	___	Goiter	___	___	Mumps	___	___	Tonsillitis
___	___	Arthritis	___	___	Gonorrhea	___	___	Osteoporosis	___	___	Tuberculosis
___	___	Asthma	___	___	Gout	___	___	Pacemaker	___	___	Tumors/Growths
___	___	Bleeding Disorders	___	___	Heart Disease	___	___	Parkinson's Disease	___	___	Typhoid Fever
___	___	Breast Lump	___	___	Hepatitis	___	___	Pinched Nerve	___	___	Ulcers
___	___	Bronchitis	___	___	Hernia	___	___	Pneumonia	___	___	Vaginal Infections
___	___	Bulimia	___	___	Herniated Disk	___	___	Polio	___	___	Venereal Disease
___	___	Cancer	___	___	Herpes	___	___	Prostate Problem	___	___	Whooping Cough
___	___	Cataracts	___	___	High Cholesterol	___	___	Prosthesis	___	___	Other
___	___	Chemical Dependency	___	___	Kidney Disease	___	___	Psychiatric Care	_____		
___	___	Chicken Pox	___	___	Liver Disease	___	___	Rheumatoid Arthritis			

EXERCISE

___None
___Moderate
___Daily
___Heavy

WORK ACTIVITY

___Sitting
___Standing
___Light Labor
___Heavy Labor

HABITS

___Smoking Packs/Day_____
___Alcohol Drinks/Week_____
___Coffee/Caffeine Drinks Cups/Day_____
___Computer Use Avg Hrs/Day_____
___High Stress Level Reason_____

MEDICATIONS

_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____
_____

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TRAITS & BELIEFS

What are your dominant personality traits that you feel you exhibit on a consistent basis? (check all that apply)

___ Habitual worry	___ Overly competitive	___ Repressed anger
___ Controlling	___ Think a lot about the past	___ Repressed guilt
___ Perfectionist	___ Think a lot about the future	___ Overly self-conscious
___ People pleaser	___ I usually hold my feelings inside	
___ Striving	___ I am good at expressing my feelings	

1. Do you have a Spiritual Practice; believe in God, the Divine or other Spiritual beliefs?

2. What is your belief system about healing:

   ___ Do you believe the body has self-correcting mechanisms?

   ___ Do you believe the body needs external means for healing?

3. We all have strengths and limitations. What are your strengths, capabilities, inner qualities you feel you can rely on?

4. How would you describe your limitations?

5. What helps you get through difficult times?

6. What is going well in your life?

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7. What are your challenges?

8. What would you like to change about yourself?

9. What changes would you like to experience as a result of Unified Therapy™?

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TRAUMA HISTORY

TIMELINE – Please list the overwhelming/traumatic events that you have experienced and the resources that were available to you at that time.

Overwhelming/Traumatic Event	Age	Help/Assistance Available
	65	
	60	
	55	
	50	
	45	
	40	
	35	
	30	

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Overwhelming/Traumatic Event	Age	Help/Assistance Available
	25	
	20	
	15	
	10	
	5	
	Birth	

PRENATAL HISTORY

Was your pregnancy planned, were you a wanted child? _____

Were you premature; were you in an incubator for more than two days? _____

Was your birth difficult? _____

Was your mother in poor physical or emotional health during her pregnancy?_____

_____

Did she experience any losses or dramatic events during her pregnancy with you? _____

_____

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Did your parent(s) want a child of the opposite gender? _____

Were you adopted? _____

As an infant, were you separated from your mother at birth? _____

Did you have any medical problems or early hospitalization? _____

Were there other children in your family? _____

Did you feel accepted by them? _____

Did your family have adequate food, shelter and other basic needs met? _____

Did you feel loved? _____

FAMILY RELATIONSHIPS

Were you separated from either parent or siblings for a length of time? _____

Where and with whom did you live with then? _____

Did any family members have alcohol or drug problems? _____

Did your parents fight? _____

_____ Physically? _____ Verbally? _____ Did you hear or see these fights?

How were you punished or disciplined? _____

_____ Were you hit? _____ How often? _____ How severely?

Did you experience any incest, molestation or inappropriate touch? _____

_____

Did you have any serious fights with siblings? _____

Ongoing difficulties with siblings? _____

Were there any other relationships coming into the home? _____

Were your parents:

_____ Married _____ Divorced _____ Remarried _____ Single

How many caregivers did you have while growing up? _____

How many places did you live while growing up? _____

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What people are or have been important resources for you? _____

_____

Briefly describe your relationship with your family (i.e., parents, siblings, spouse/significant other, children, etc.)

_____

_____

_____

SCHOOL/WORK EXPERIENCES

Did you feel teased, tormented, bullied or threatened? _____

Did you feel excluded, outcast or ostracized? _____

Did you experience prejudices? _____

Are you satisfied with your career/school? _____

PHYSICAL HISTORY

Have you had any hospitalizations, surgery or serious illness? _____

Have you had any long-term or difficult medical treatments? _____

Have you had any life-threatening conditions? _____

Have you had any accidents (burns, falls, broken bones, auto accident, etc.)? _____

_____

Have you had any difficult experiences with doctors, nurses or hospitals? _____

How did you respond to the situation? _____

Have you experienced chronic, unexplained physical ailments? _____

What was going on in your life when symptoms were first apparent? _____

_____

Headaches _____

Stomach aches _____

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Colitis _____

Irritable bowel syndrome (IBS) _____

Autoimmune disorder _____

Joint pains _____

Skin conditions _____

Other _____

FRIGHTENING EVENTS

Have you had any direct experience with human-caused assault (kidnapping, mugging, rape, arson etc.)?

_____

Have you had any direct experience with nature-based fear, like tornado, earthquake, flood, fire etc.?

_____

Have you witnessed any frightening events? Explain what, and at what age?

_____

Do you have a close connection to someone who experienced a frightening event?

_____

Have you had a frightening spiritual or religious experience?

_____

LOSSES

Have you experienced any deaths of significant others, what circumstances?

_____

Have you experienced the loss of a treasured pet?

_____

Have you experienced the loss of a pregnancy, through what means?

_____

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Have you experienced a serious break-up with good friends, boy/girlfriend, spouse or significant other?

Have you experienced a loss of job, what circumstances?

Have you experienced a loss of home, what circumstances?

OTHER UPSETTING LIFE EVENTS OR EXPERIENCES

Please feel free to add any additional information you feel would be helpful for me to know (i.e., testing of addiction, suicidal ideation or attempts, depression, anxiety, etc).

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WHAT IS YOUR ACE SCORE?

I'm sure that title probably made you ask the following question. "What is an ACE Score?" Glad you asked! ACE stands for adverse childhood experience. The score attempts to determine how many adverse experiences an individual has had in their childhood because the higher the score, the greater the risk of having some serious health conditions later in life.

While most humans wait until these conditions show up and then want medications to fix the health condition, few realize just how much impact these early experiences had upon our life. If we realize the impact they had upon our life, we are often led to believe there is little we can do about them now, short of taking medications and going through medical procedures. However, this is not necessarily the case.

It does not require that you have been through horrendous trauma as a child because at the end of the day, trauma is trauma. Yes, the more you have to deal with from childhood, the more difficult the challenge to overcome it. We've all got something in our past most likely and instead of looking at it as a badge of honor or something to run away from, we should learn how to deal with it in our life.

The ACE study brought together science with somatic reality. It clearly demonstrated that if you have adverse conditions, you are more likely to develop serious health conditions later in life. Again, just because this has happened to you, it does not mean you cannot change the course of your life in the future. Health conditions do not need to be a cause and effect relationship.

Excerpted from Don Shetterly, LMT

There are 10 types of childhood trauma measured in the ACE Study. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.*

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

   No _____ If Yes, enter 1 _____

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   No _____ If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   No _____ If Yes, enter 1 _____

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4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   No _____ If Yes, enter 1 _____

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   No _____ If Yes, enter 1 _____

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?

   No _____ If Yes, enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   No _____ If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   No _____ If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   No _____ If Yes, enter 1 _____

10. Did a household member go to prison?

    No _____ If Yes, enter 1 _____

Now add up your "Yes" answers: _____

This is your ACE Score

*Note: There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, etc. The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature. The ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

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Now that you've got your ACE score, what does it mean?

First….a tiny bit of background to help you figure this out…..The CDC's Adverse Childhood Experiences Study (ACE Study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

The first research results were published in 1998, followed by 57 other publications through 2011. It showed that:

- childhood trauma was very common, even in employed white middle-class, college-educated people with great health insurance;
- there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence;
- more types of trauma increased the risk of health, social and emotional problems.
- people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse.

A whopping two thirds of the 17,000 people in the ACE Study had an ACE score of at least one – 87 percent of those had more than one. Eighteen states have done their own ACE surveys; their results are similar to the CDC's ACE Study.

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma. The higher your ACE score, the higher your risk of health and social problems. (Of course, other types of trauma exist that could contribute to an ACE score, so it is conceivable that people could have ACE scores higher than 10; however, the ACE Study measured only 10 types.)

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

(By the way, lest you think that the ACE Study was yet another involving inner-city poor people of color, take note: The study's participants were 17,000 mostly white, middle and upper-middle class college-educated San Diegans with good jobs and great health care – they all belonged to the Kaiser Permanente health maintenance organization.)

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CONSENT FOR THERAPY

1. The course of the session will be determined by your needs at the time of the appointment. There will be a brief consultation at the beginning of the session to determine those needs.
2. This work is intended for stress reduction, self education, postural alignment and enhancing the body's self healing re~regulating mechanisms. It is not medical in nature and is not a substitute for medical attention when needed. You acknowledge your responsibility for consulting a doctor when it is appropriate.
3. Your permission and consent is requested to apply those techniques which are appropriate in helping you establish balance in your body.
4. In the course of this session, it is possible that uncomfortable sensations may occur. It is important that you express any feelings of discomfort so that we may work together.
5. When we make an appointment, it is an agreement. Please allow at least 24 hours notice if you need to reschedule to avoid a cancellation fee.
6. I understand that payment is due at the time of our appointment unless other agreements have been made.
7. I fully acknowledge my own responsibility for consulting a qualified physician for any physical ailment.
8. HIPPA Statement – A copy of our HIPPA Statement is available on our website at http://www.jimfazioib.com/New_Client_Information or a copy can be obtained at this office upon request. Your signature below acknowledges that you have received and read the HIPPA statement.
9. I give Jim Fazio, my Licensed Massage Therapist, full permission to legally consult with his professional health care mentors in efforts to assist with my healing.

_____ _____

Client Name Date

_____

Parent, Guardian or Client's Legal Representative

_____

Signature

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HIPPA ACKNOWLEDGEMENT

Protecting Your

Confidential Health Information

Is Important To Us

Notice of Privacy Practices

Client Acknowledgment

Thank you very much for taking time to review our HIPPA Statement and how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging that the terms have been read and understood.

_____ _____

Client Name Date

_____

Client, Guardian or Client's Legal Representative

_____

Signature

List below the names and relationship of people to whom you authorize Integrative Bodywork, Inc to release PHI:

_____ _____

_____ _____

_____ _____

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FINANCIAL RESPONSIBILITY

1- Please read and sign this form before your initial session.

2- Full payment is due at the time of service.

3- You may use your medical insurance, but we will call the insurance company to verify your benefits. We will file insurance claims to your company however, if service is denied, is not a covered service, or if you are found to have a deductible or co-insurance amount, you will be responsible for paying your co-payment or your balance at the time of your appointment.

4- Sometimes the insurance will deny services. If this occurs, you as the client are responsible for payment. We are sensitive to this issue and we will try to warn you if we feel a service may not be covered. Ultimately the insurance contract is between you, your employer and your insurance company.

5- We do not mail invoices or statements to clients for balances. If we receive notice that there is a balance on your account, payment will be due immediately. Please refer to your EOB from your insurance company for the balance.

6- CASH clients are required to pay the full amount at the time of service. We also accept credit card payments.

7- We will charge a fee of $30.00 per any return checks, for uncollected funds or NSF.

8- You will be charged for the **full amount** of your appointment if your do not cancel 24 hours prior to your scheduled appointment. This amount must be paid in full prior to your next scheduled appointment.

_____ _____

Client Name Date

_____

Client, Guardian or Client's Legal Representative

_____

Signature

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CANCELLATION POLICY

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, car problems and illness are just a few reasons why one might consider cancelling an appointment.

In our desire to be effective and fair to all of our clients, and out of consideration for your therapist's time, we have adopted the following policies:

CANCELLATIONS

- **24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us 24 hours advance notice, you will be charged for the **full amount** of your appointment. This amount must be paid in full prior to your next scheduled appointment.

NO-SHOWS

Anyone who either forgets or consciously chooses to forgo their appointment without the appropriate notice for whatever reason will be considered a "no-show". You will be charged the full amount for your missed appointment and future service will be denied until payment is made in full.

ARRIVING LATE

- Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours.
- Depending upon how late you arrive, your therapist will determine if there is sufficient time remaining to start your session.

Regardless of the length of the session actually given, if given at all, you will be responsible for payment of a "full" session.

Please note that there is a high demand for this nervous system re~regulation therapy. Out of respect and consideration to your therapist and our other clients, kindly plan accordingly and be on time.

Client Name _____ Date _____

Client, Guardian or Client's Legal Representative _____

Signature _____

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