DharmaGaia Integrative Medicine

Empowering the Healing Process!

Name: ____

Address: _________________________ City____________State____ Zip _________

Age: _____ Date/Place of Birth: ____

Home/ cellular phone number: __________________ Email: __________________

Occupation:______________________Marital Status: _________________________

In Emergency Notify: ____

Referred by/How did you hear about us: __________________________________

In the event you would like to improve your relationship with another person, please provide their birthdate as well: ____________________________________

____

The information below will help me to address your issues in a complete and timely manner. Please feel free to be absolutely honest; your answers are part of your confidential record. Use the back of the page if necessary.

MAIN PROBLEM YOU WOULD LIKE TO ADDRESS/How can I serve you? ___________

____

____

____

How long has it been since you first noticed this problem? ____________________

What kinds of solutions have you have you tried? ____________________________

____

____

Are you taking any medications? (If yes, please describe) ____________________

____

Do you have any allergies? (If yes, please describe) __________________________

Do you smoke? ____ How many packages per day?____________________________

Do you drink alcohol? _____ How often?___________________________________

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Do you use any drugs?____

How many cups of coffee do you drink per day?__________________________

Is there any history of cancer, diabetes, genetic disease or any other important illness in your family?____

____

____

PAST MEDICAL HISTORY (PLEASE INCLUE DATES):

☐ Allergies: ____________________ ☐ Cancer: _______________________

☐ Diabetes: ____________________ ☐ Hepatitis: ______________________

☐ High blood Pressure: __________ ☐ Heart disease: ___________________

☐ Seizures: _____________________ ☐ Rheumatic Fever: ________________

☐ Venereal Disease: ______________ ☐ Thyroid disease: _________________

☐ Surgeries: ____

☐Other significant illness: (Describe): _____________________________________

____

☐ Accidents or significant trauma/ fractures (describe): ______________________

____

____

OTHER RELEVANT MEDICAL HISTORY: ___________________________________

____

____

____

How often do you exercise? _______What type of exercise? _________________

Do you practice yoga? _____ How often? _________ What type?____________

Have you had a kabalistic counseling session before? _______ If yes, with whom and when?____

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I, the undersigned (client), do hereby affirm that I fully understand and agree to the following declarations:

1. Dr Manzanares, cannot make predictions or promises as to the outcome of the sessions, other than she will give me her devoted best effort(s) and recommendations based upon a combination of her experience and her knowledge.

2. I understand that the main person responsible for my own healing and the one who decides to follow any given recommendations is myself.

3. I understand that if I arrive late to my scheduled appointment, my session will end at the originally scheduled time If my consultation starts late, Dr. Manzanares, will make up the time at the end of the session if possible or will reduce the fee accordingly. I agree to pay the full fee for the consultation missed on my behalf that is not cancelled with a minimum 24 hours notice.

4. The communication between you and Dr. Manzanares is confidential. This means that she will not discuss your session orally or in writing without your expressed written permission. Dr. Manzanares has ethical and legal obligation to break confidentiality if there's a reason to think that you have a serious intent to harm yourself or someone else, if you introduce your emotional conditional into a legal proceeding or if the records are subpoenaed by a court of law.

Signature ______________________________ Date ____________________

Printed Name: ______________________________

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