CLIENT INTAKE FORM

NAME:______________________________________DATE OF VISIT:__________________________

E-MAIL:____________________________________MAILING LIST YES/NO?:___________________

ADDRESS:____

____

____

DATE OF BIRTH:__________________HEIGHT:_________________WEIGHT:___________________

OCCUPATION:____________________WORK PHONE:______________HOME PHONE:______________

RELATIONSHIP STATUS:_____________CHILDREN:_________________REFERRED BY:______________

EMERGENCY CONTACT PERSON:_______________________________PHONE:____________________

THERAPIST(NAME & PHONE):____

PHYSICIAN(NAME, ADDRESS, PHONE):____

LAST MEDICAL EXAM:____

THERAPEUTIC/SPIRITUAL GROWTH EXPERIENCE:____

REASON FOR VISIT:____

____

____

____

DATE OF ONSET:_________________________SUDDEN:_______SLOW:______

CURRENT/PREVIOUS TREATMENTS:____

____

____

____

ANTIBIOTICS/MEDICATION CURRENTLY TAKEN:____

____

NON-MEDICINAL DRUGS CURRENTLY TAKEN:____

ALLERGIES:____

ALCOHOL INTAKE:____________________________TOBACCO/CIGARETTES:__________________________

DAILY FLUID INTAKE(NOT ALCOHOL):____

GENERAL TYPE OF DIET:____________________________________EXERCISE:___________________________

VISON:____WEAR GLASSES/CONTACTS?:_____________________

SMELL:____________________________HEARING:_________________________TASTE:__________________

INJURIES PRESENT OR PAST:____

____

ACCIDENTS PRESENT OR PAST:____

____

SURGERIES PAST OR FUTURE:____

____

PLEASE INDICATE IF YOU HAVE HAD ANY TRAUMA IN YOUR LIFE AND AT WHAT AGE, MONTH AND YEAR OF THE TRAUMA; FOR EXAMPLE: SEPARATION, DIVORCE, DEPRESSION, LOSS OF JOB, DEATH OF A LOVED ONE OR OTHER IMPORTANT INCIDENT.

____

____

WHAT DO YOU EXPECT FROM THIS SESSION AND LONG TERM:

____

____

____

SISTERS/BROTHERS:____

RANK IN THE FAMILY:____

Family Heredity Main Family Illnesses

FATHER DECEASED YES/NO____________AGE___________ILLNESSES______________________________

MOTHER DECEASED YES/NO___________AGE___________ILLNESSES______________________________

BROTHERS DECEASED YES/NO__________AGE___________ILLNESSES______________________________

SISTERS DECEASED YES/NO____________AGE___________ILLNESSES______________________________

PLEASE MARK THE FOLLOWING AREAS OF DISEASE OR SYMPTOMS AS "C" FOR CURRENT "P" FOR PAST "O" FOR OCCASIONAL AND "CH" FOR CHRONIC

EMOTIONAL/PSYCHOLOGICAL		NEUROLOGICAL		RESPIRATORY		ENDOCRINE	
DEPRESSION		EPILEPSY		BRONCHITIS		ADRENAL	
EATING DISORDER		DIZZINESS		PNEUMONIA		PITUITARY	
MOOD SWINGS		INSOMNIA		PLEURISY		HYPERTHYROID	
SUBSTANCE ABUSE		MIGRAINES		TUBERCULOSIS		HYPOTHYROID	

AUTO-IMMUNE		MUSCULO-SKELETAL		DIGESTION		REPRODUCTIVE	
AIDS/HIV		ARTHRITIS		CONSTIPATION		SEXUALLY TRANS. DISEASE	
ALLERGIES		RHEUMATISM		DIARRHEA		ENDOMETRIOSIS	
CANCER(TYPE)		BACK PAIN		GASTRITIS		MISCARRIAGES	
FATIGUE		CARPAL TUNNEL		HEPATITIS		ABORTION	
FEVER		GOUT		HYPOGLYCEMIA		PREGNANCIES	
FIBROMYALGIA		SKIN DISORDER		JAUNDICE			
FUNGAL INFECTIONS				LIVER DISORDER			

Auto-Immune		Musculo-Skeletal		Digestion		Reproductive	
Herpes				Ulcers			
Lyme Disease				Pancreas			
Mononucleosis				Flatulence			
				Diabetes			

Ear/Nose/Throat		Cardio-Vascular		Urinary		Major Illnesses	
Earaches		Angina		Bladder Infection		Chicken Pox	
Headaches		Heart Attack		Kidney Stones		Measles	
Jaw Pain		Heart Failure				German Measles	
		Hypertension				Mumps	
		Heart Attack				Whooping Cough	
		Stroke				Rheumatic Fever	
						Scarlet Fever	

CONSENT FORM FOR TREATMENT

Please take a moment to carefully read the following information, and sign where indicated. As a Natural Health Consultant, Brennan Healing Science Practitioner, Indigenous Practitioner, Conflict Resolution Facilitator and Peacemaker Minister, I do not medically diagnose or prescribe treatment. My approach is holistic, focusing on you as a complex, dynamic, unique being-body, mind, and spirit and I serve as a facilitator in your process of healing. I have had a private practice since 1994.

We may explore areas that influence your state of well-being, such as your health history, life stressors, your belief systems and attitudes, your family and childhood history, diet, exercise, and how you are in relationship. Your sharing is always kept confidential. I do, however, discuss clients with my professional supervisor or professional peers for the purpose of my continuing professional development.

The hands-on-healing techniques balance, clear, and charge your energy field and system, remove energetic blocks that lead to disease, and enhance your body's natural healing potential. At times I will touch your body, and at other times I may work with your energy field off your body. If at any time during the session you are uncomfortable, it is your responsibility to inform me. Self-care is an extremely important part of your healing process.

I prefer to set up a regular schedule to work with you although there is never an obligation to continue treatment. I do request 24 hours notice of cancellation in advance; otherwise, my policy is to charge you the full session fee. The exception is emergencies and illness. The fee for the first session is $150.00 (duration one hour and a half). Other scheduled sessions are at a fee of $100.00 (duration one hour and may be up to one hour and fifteen minutes), payable by check, money order or cash at time of session.

Due to the nature of this work, I recommend that you refrain from using alcoholic beverages for 24 hours following your session. I am most happy to answer any questions regarding my services, and I also encourage you to express any concerns. I look forward to working with you.

Sincerely,
Rosa Bergola

I have read and understand the above information provided by Rosa Bergola.

I further understand that her services are not to be construed as medical examination, diagnosis, or a substitute for medical treatment, and that nothing said or done during the course of the session or sessions given should be construed as such.

The client confirms that s/he has presented themselves in their own name, in good faith and for no other reason than to obtain a natural therapy treatment.

SIGNED____ **DATE**__________________________________

National Association of Naturopaths

File Opening Formality

NAME___________________________________ SURNAME__________________________________

AGE____ GROUP INS. YES________ NO____________

REIMBURSEMENT FOR NATUROPATHY

YES________ NO____________

ADDRESS

____

____

REFERRED BY ____

TELEPHONE HOME (_________)____

OFFICE (_________)____

REASON FOR CONSULTING ____

DATE OF FIRST VISIT ____

The client has read and understood the following
The receipt issued by the therapist is given as an acknowledgement for the sum of money received by the client for services rendered. The use of this receipt is for no other purpose other than for the reimbursement of monies by your insurance company and it is the exclusive responsibility of the client to file for reimbursement. The therapist is not involved in any way with the admissibility or non admissibility of this receipt.

The client acknowledges that s/he has presented themselves under his real name, in goodwill and for no other purpose than to receive a natural therapy session.

SIGNED IN ____

DATE ____

SIGNATURE ____

NAME OF CLIENT IN BLOCK LETTERS ____

PROVISIONS RELATED TO THE ACT RESPECTING THE PROTECTION OF PERSONAL INFORMATION IN THE PRIVATE SECTOR (BILL 68)

You have given us information regarding your private file. Following the adoption of Bill 68, and unless otherwise instructed by yourself, we shall consider that you consent to our keeping in a file, all information you have already given or may give us, orally or in writing. We shall also consider, unless otherwise instructed by yourself by registered mail, that your consent will be valid for a period of five (5) years.

CONSENT

I hereby consent freely to the fact, that

ROSA BERGOLA

Will gather in a file from now on, all the information that I will transmit whether it be written, oral or computerized.

SIGNATURE____ **DATE**___________________________