S.E.A. Calming the Sea Inside

Simple Medical History

Personal Information			
Name:		Age:	
Address:		Date of Birth:	
Email:		Birth Order:	
Best phone:		# of siblings:	

Current Medications	**Current conditions**

Food Allergies	**Medication Allergies**	**Any Other Allergies**

Any complications your mother's pregnancy	**Any complications during your delivery**
	Type of medication mother given:

Illnesses or Injuries in first 5 years / Or other times	**Hospitalizations in first 5 years / Or other times**
Any car accidents?	**Any head injuries, loss of consciousness?**
Any recurring childhood nightmares?	**notes**

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Name:	Date:
Email:	Phone:

Mark any that apply to what brings you in today.

	Ambition		Friends / social issues		Panic
	Anger Issues		Frustration		Perfectionism
	Anxiety		Guilt or shame		Procrastination
	Authority Issues		Grief / sorrow		Regrets
	Blocked Creativity		High stress		Rejection
	Boundaries		Immune system		Relationship Issues
	Career Issues		Indecisive or indifferent		Repetitive thoughts
	Concentration		Learning Issues		Self Control
	Compulsive behaviors		Low self esteem		Self Sabotage
	Confusion		Memory Issues		Separation anxiety
	Connection		Mood swings		Sleep Cycles
	Control Issues		Motivation		Stress
	Decision making		Neck pain		Tension
	Denial or avoidance		Negative self talk		Time Issues
	Depression		Nervousness		Trust
	Dizziness		Nightmares		Unhappy
	Dreams		Organization		Withdrawal

Please note any condition you currently are working on with a Doctor or Therapist:

What brings you in today?

UNDERSTANDING AND CONSENT

I understand that the therapy offered here is for the purpose of stress reduction, relief from loss of brain synchronization or for increasing energy flow. I understand that the practitioner does not diagnose illness, disease or any other physical or mental disorder. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor does the practitioner perform any spinal manipulations. It has been made very clear to me that this work is not a substitute for medical examination and/or diagnosis and it is recommended that I see a physician for any physical ailment that I might have. Because it is important for this practitioner to be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical health.

Signature:____Date:____________

You have my permission to share my records and or converse with Dr. Knutson, Dr. Chan, Dr. Lennihan, Dr. Lategan, Dr. Krebs, Dr. Grace concerning my case _____