Client Name:_________________________

Be the Change Health and Wellness
INTENSIVE OUTPATIENT PROGRAM
INTAKE QUESTIONNAIRE

Personal Information:

Todays Date:____________________

Name_______________________________ Birthdate____________________________

Address____

Cell Phone Number_____________________ Home Number____________________

Emergency Contact Person:

Name_____________________________________Relationship:_________________

Address:____

Phone(s): cell:_________________________Home:__________________________________

E-mail: ____

GOALS FOR TREATMENT

Describe the issue/issues that have been problematic to you:

What do you hope to gain from participating in services at Be The Change Health & Wellness?

Client Name:___________________________

What strengths do you possess that would help you reach these goals?

What might get in the way of your reaching these goals?

Is there anything that would be helpful for us to know about you?

MEDICAL HISTORY

Date of last physical exam: ________________________________

Physician :____

Have you, or are you, being treated for any of the following, or are you currently having symptoms related to any of the following? (Please circle those that apply.)

Migraines, Headaches, Dizziness, Head Trauma, Stroke, Vision Problems/Loss

Hearing Loss or Ringing in Ears, Allergies, Seasonal or Other, Heart Attack,

High or Low Blood Pressure, Other Heart Conditions, Asthma, Gastric Reflux or Ulcers,

Pancreatic or Gall Bladder Disease, Other Digestive Problems, Urinary Problems

Sexual Dysfunction, Thyroid Problems, Diabetes, Bleeding Problems/Easy Bruising, Skin

Problems, Back or Joint pains/Arthritis, Nerve Numbness or Sensitivity, Seizures,

Muscle Weakness/Injury, Arthritis, Menstruation Irregularity, Hysterectomy, HIV, Hepatitis

Client Name:____________________________

Insomnia, Sleep Apnea, Other Neurological Disorder(s),

Please comment on any above concerns:
____
____
____

List current exercise involvements:
____
____

MEDICATIONS

Please list any current prescription medication:

Medication Dosage: ______________________ Date First prescribed: ______________________

____
____
____
____
____

Current over-the-counter medications (including vitamins, herbal remedies, etc.):
____

Do you have any allergies and/or adverse reactions to medications:

____

If yes, please list:
____
____

Client Name:____________________________

SUBSTANCE USE HISTORY

Please list the frequency and amount of uses for the following substances:

Tobacco____

Caffeine____

Alcohol____

Marijuana____

Cocaine____

Crack____

Ecstasy____

Heroin____

Inhalants____

Methamphetamines____

Pain Killers____

PCP/LSD____

Steroids____

Tranquilizers____

Other____

BEHAVIORAL ADDICTION HISTORY

If you have a history of any of the following addictive processes, please circle:

Gambling spending sex computer games eating disorders relationship addiction/codependency exercise work pornography

Please describe the frequency for above addictions:

____
____
____

Client Name:___________________________

ABUSE HISTORY

Please circle if you have experienced any of the following types of trauma or loss:

Emotional abuse   Neglect   Lived in a foster home   Sexual abuse   Violence in the home

Multiple family moves   Physical abuse   Crime victim   Homelessness   Parent substance abuse

Parent illness   Loss of a loved one   Teen pregnancy   Placed a child for adoption   Financial problems

Work place trauma   Relationship trauma   Sexual Trauma

FAMILY PSYCHIATRIC HISTORY:

Please indicate if your biological relatives have experienced any of the following.

___Anxiety ___Completed Suicide ___ADHD ___Psychosis
___Bipolar Disorder ___Depression ___Substance Abuse_____ Addictions

Please describe the severity and time course for any of these conditions and describe any other psychiatric conditions that run in your family:
.____
____
____
____

Please list any family history of mental health issues or substance use:

Name   Relation to you   Issue

____
____
____
____
____
____

Client Name:___________________________

FAMILY/RELATIONSHIP HISTORY (please circle)

Do you live alone? No / Yes List who lives with you:

Are you married or in a relationship currently? No / Yes

Name of significant other:

Significant other's employment:

Describe relationship with current significant other:

How many previous marriages or long term relationships have you had?

Do you have children? No / Yes (List)

Name	Age	Relationship	Living with you?

Do you have any pets? No / Yes

Where did you grow up?

Did your parents stay together while you were growing up? No / Yes

How old were you if/when they separated?

Client Name:_________________________

Who did you live with after the separation?

Father's occupation while you were growing up:

Mother's occupation while you were growing up:

How many siblings do you have? None ___ Brothers ____Sisters________

Describe your current family:

SOCIAL HISTORY

Do you have a social support system? Describe:

____
____
____
____

What are your barriers to social relationships?

____
____
____
____

Do any addictive processes limit or affect your social relationships? Y / N Please explain:

____
____
____
____

EDUCATION/LEARNING

Highest education/degree completed:

List further professional training:

What type of jobs have you had in the past?

Client Name:____________________________

Have you had any job related issues?

How do you best learn?

SPIRITUALITY:

Describe your spirituality:

____
____
____

What activities do you participate in that aids in your spirituality?:____
____
____
____

How does your spirituality aid or negate your mind/body/spirit healing?:
____
____
____
____

Has your spirituality been affected by addictions or other trauma experiences?:
____
____
____
____

Client Name:____________________________

Office Use Only:

Clinician Name:____________________________________Date:______________________

Recommendations:

____
____
____
____
____
____
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____
____

Client Name:___________________________

Informed Consent for Esogetic Color Puncture Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive **Esogetic Colorpuncture treatment/ needleless acupuncture and or Induction Treatments** with the Wave or Home Synapsis Device. Please be aware of my practice regarding confidentiality for your health information. Your rights as a patient are shown below. My privacy practices are shown in a separate document provided to you.You have a right to withdraw this informed consent, in writing, at any time.

DISCLAIMER: This service does not offer medical advice, and nothing contained in the service is intended to constitute professional advice for medical diagnosis or treatment. Advice received via this service should not be relied upon for medical, legal, or financial decisions, and you should consult with an appropriate professional for specific advice tailored to your situation. You should always seek the advice of your physician or other qualified health provider prior to starting any new treatment or with any questions you may have regarding a medical condition.

What is Esogetic Colorpuncture:

Esogetic Colorpuncture is a complete system of acu-light therapy developed over the past 25 years by German naturopath and acupuncturist, Peter Mandel. It combines concepts of acupuncture with the latest research on the way light functions in the body coming from the field of modern biophysics. Like acupuncture, colorpuncture presupposes that the balanced flow of energy through the meridian system will support good health. However, colorpuncture achieves this by introducing vibrational information into the body in the form of different colored light frequencies via the meridian system.

For these treatments, a hand-held acu-light pen with insertable colored glass tips is used. The tool emits incandescent light and is battery operated. Each colored tip is precisely set at a specific frequency within the frequency band for each color.

A lengthy professional association with German biophysicist, Fritz Albert Popp provided Mandel with the theoretical basis of Esogetic Colorpuncture. In his studies of human cell communication, Popp demonstrated that normal living cells emit a steady stream of photons (particles of light) called biophotons. Popp hypothesized that these act as carriers of information in living organisms and that a cell will show an increased emission of biophotons (and disturbed information flow) whenever its functions are no longer in a state of balance. Further, the change in the biophoton emissions of one cell will eventually disturb the biophoton emissions in neighboring cells (imagine a pebble dropped in a pond with its spreading ripples). This change from harmoniously oscillating light eventually leads to incoherence and disease.

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The Induction Therapies:

Scientific research now shows that the impulses of our brain waves are a component of consciousness. It is also true that health and illness have been found to correspond to changes in the natural brain rhythms. Therefore, a change in our brain rhythms brought on by stress or emotional conflict can gradually begin to effect our physical well-being. The Induction Therapies aim to introduce the vibrations innate to the brain (beta, alpha, theta and delta) via acu-points on the skin. This is done using specially designed “biofeedback” devices called the Induction Wave or Home unit, as well as the Induction Point unit. Through the precise transmission of the brain waves via the skin and the meridians, we can begin to talk to the body like a healthy brain would and, in this way, slowly guide the body’s information toward health. For more information on the Induction Therapies, you can visit: www.esogetics.com/english/induction_holistic_therapy.html.

Esogetic Sound Therapies:

Peter Mandel collaborated with the music researcher couple Korten and Helm, to literally translate some of his color treatments into sound treatments, using precise mathematical formulas. These sound therapies, made up of specific sequences of tonal frequencies, are conducted as information through the ears to the brain and then into the body. These sound frequencies help are supportive and stabilizing for body and brain functions.

I have read and fully understand all terms and statements herein. I have truthfully and accurately stated all conditions that I am aware of and to the best of my ability. I will inform this provider of any changes in my status at my earliest convenience.

By my signature below, I attest that my rights have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and Grievance Procedure, and a copy of the Notice of Privacy Practices.

- ○ I am not pregnant, and I will inform my therapist before receiving a treatment if I become pregnant
- ○ I do not have epilepsy and I will inform my therapist before a treatment if I develop epilepsy
- ○ I will inform my therapist of any medical changes before a treatment

____ ___________________________________

Client Signature Date

Client Name:__________________________

Be the Change Health and Wellness

Informed Consent for Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of the practice regarding confidentiality for your health information. Your rights as a patient are shown below. Privacy practices are shown in a separate document provided to you.

1. The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs: improved communication skills, clearer thought process, and more stable mood.
2. Services provided may include psychiatric assessment, case management, group, individual, family, and couples therapy. If medication is a part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.
3. The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experiences with your treatment providers. Certain medications may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluation. It is your right, unless under court order, to decide whether or not you want to take any medication.
4. If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.
5. The treatment staff will discuss treatment recommendations, benefits of treatment, duration of treatment and outcome of treatment as well as associated fees with services.
6. The possible **benefits of EMDR** treatment include the following:

   • The memory may be remembered but the painful emotions and physical sensations and the disturbing images and thoughts may no longer present.

   • EMDR may help the mind reintegrate the memory and store it more adaptively. The client's own mind reintegrates the memory and does the healing

   The possible **risks of EMDR** treatment include the following:

   • Reprocessing a memory may bring up associated memories. This is normal and those memories will be contained so that they may be processed with a therapist at a later date.

   • During EMDR, the client may experience physical sensations and retrieve images, emotions and sounds or smells associated with the memory.

   • Reprocessing of the memory normally continues after the end of the formal therapy session. Other memories, flashbacks, feelings and sensations may occur. The client may have dreams associated with the memory. Frequently the brain is able to process these additional memories without help, but arrangements for assistance will be made in a timely manner if the client expresses difficulty coping.

________**Initial Here** if you have any of these **medical issues: pregnancy, epilepsy, eye issues** such as retinal tear or contacts, as they may require medical consent before participating in EMDR.

7. The treatment plan may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.
8. You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.
9. Services never involve sexual contact between therapist and client; this is unethical and against the law.
10. This informed consent will be in effect no longer than fifteen months from the time that consent is given
11. You have a right to withdraw this informed consent, in writing, at any time.
12. Emergency after hours procedure will be reviewed by treatment staff.
13. Your therapist will not communicate with you via their private social media.

Denial of patient rights

Your rights may only be denied in certain circumstances such as:

1. When there is a danger to life or health of the client or potential harm to others.
2. Suspected cases of child or elder abuse or neglect. (s. 48.98)
3. A lawful order of the court to which you must comply.

Client Name:___________________________

By my signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and the Grievance Procedure, and a copy of the Notice of Privacy Practices.

______________________________________ ____________________________________

Client/Guardian Signature* Date

______________________________________ ____________________________________

Client's Name (Please Print) Date of Birth

______________________________________ ____________________________________

Witness Date

* If client does not sign, please document reason:
____

Client Name:___________________________

FINANCIAL POLICY AND AGREEMENT

Welcome to Be the Change Health & Wellness and thank you for choosing us as your wellness provider. We look forward to providing you quality treatment and professional service. Please understand that payment of your bill is considered a vital part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment. Be the Change Health & Wellness will not be billing insurance for intensive therapy payments.

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $____200____ per session. **Please help us serve you better by keeping scheduled appointments.**

Treatment Plan

Your therapist is responsible for informing you of a tentative treatment plan regarding your therapy. Together, you and your therapist can modify or alter this plan as treatment continues.

Fee Agreement

The agreed upon fee for professional services is:

$_____________________ for initial session and $______________________ per 45-50 minute session

I agree to pay a minimum of $______________ toward the professional fees at each session.

$_____________________ for a healing intensive of ____________ hours (Payment for healing intensives are due at the time of

booking)

Date paid________________________________

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this policy. I acknowledge that I am financially responsible for any unpaid balance.

____

Signature of Patient or Responsible Party Date

____

Relationship of Responsible Party

Client Name:___________________________

Issues to Rule Out

1)

2)

3)

Possible Medical Issues

1)

2)

3)

Client Name:___________________________