



Client Intake Form

Welcome to Health Freq Bioenergetic and Natural Medicine!

As a natural wellness practitioner, it is my purpose to help you achieve your desired wellness goals using the holistic approach to healing. My core principle is to teach you methods of healing, to allow you to take back control of your health and wellbeing. What I offer includes natural methods of healing and therefore will recommend foods and herbs that will help bring your body into balance. Treatments are tailored to support your unique needs and will encourage your body's innate ability to heal.

Therapies used in my practice include: Nutrition Therapy and Coaching, Traditional and Neo-biofeedback, Auricular Therapy, Sound Therapy, Homeopathy, Iridology, Medical Astrology, Energy Work, Access Bars, Reflexology, Essential Oils, and more...

DISCLOSURE AND PRACTICE POLICIES STATEMENT

Required for New Patient Consultation

1. The completed new client questionnaire. Please allow 30-45 minutes to complete most of this questionnaire.
2. Please send prior to your visit any labs, blood tests, or other pertinent medical information you think may be helpful.

Under current Colorado law Nutrition Therapy and Bioenergetic Medicine is not deemed the practice of medicine. The services provided by Melissa Simmons are at all times restricted to consultation on the subject of lifestyle and nutritional matters.

Health Freq Bioenergetic and Natural Medicine

Symptom Questionnaire

Digestive Tract

Nausea or vomiting
Diarrhea
Constipation
Bloated feeling
Belching or passing gas
Heartburn

Total

Ears

Itchy ears
Earaches, ear infections
Drainage from ear
Ringing in ears, hearing loss

Total

Emotions

Mood swings
Anxiety, fear, or nervousness
Anger, irritability or aggressiveness

Total

Energy/Activity

Fatigue, sluggishness
Apathy, lethargy
Hyperactivity
Restlessness

Total

Eyes

Watery or itchy eyes
Swollen, reddened, or sticky eyelids
Bags or dark circles under eyes
Blurred or tunnel vision
Slurred speech

Total

Head

Headaches
Faintness
Dizziness
Insomnia

Total

Heart

Irregular or skipped heartbeat
Rapid or pounding heartbeat
Chest Pain

Total

Joints/Muscles

Pain or aches in joints
Arthritis
Stiffness or limitation in movement
Pain or aches in muscles
Feeling of weakness or tiredness

Total

Lungs

Chest congestion
Asthma, bronchitis
Shortness of breath

Total

Mind

Poor memory
Confusion, poor comprehension
Poor concentration
Difficulty in making decisions
Stuttering or stammering
Learning disabilities

Total

Point Scale:

0 = Never or almost never have the symptom.
1 = Occasionally have it; effect is not severe.
2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

Informed Consent for Treatment - Health Freq Bioenergetic and Natural Medicine

I, _____, understand that methods of treatment used in this practice may include, but is not limited to: Nutrition Counseling, Traditional and Neo-Biofeedback, Lifestyle Coaching and Auriculotherapy.

Initials_____

I understand that Melissa Simmons is not a medical doctor. If a medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor. The advice or treatment provided by Melissa Simmons should not in any way be confused or replace the advice of a licensed medical doctor.

Initials_____

I understand that any medical records and lab reports I share with Castle Rock Bioenergetic and Natural Medicine will be kept confidential. If at any time it becomes necessary to share my health information, it will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledge receipt.

Initials_____

I understand that a health record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Initials_____

I understand that the form of care provided at this practice is based on holistic medicine and other supportive principles and practices. I recognize that even the gentlest therapies may cause complications in certain physiological conditions such as pregnancy, lactation, those on multiple medications, and/or medical implants such as, but not limited to, a pacemaker. As a client, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment.

Initials_____

I understand that health risks associated with this form of treatment include but are not limited to: aggravation of pre-existing symptoms and/or allergic reactions to supplements or herbs.

Initials_____

I therefore confirm that I will inform, and will continue to inform, Melissa Simmons fully of my medical history, family history, medications and/or supplements I am currently taking (prescription & over the counter), or was previously taking. If female, I will advise Melissa Simmons immediately if I am pregnant, suspect I am pregnant, am trying to become pregnant, or breast-feeding, and will continue to do so.

Initials_____

I understand that Melissa Simmons will answer any questions that I have to the best of her ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect Melissa Simmons to be able to anticipate and explain all risks and complications.

Initials_____

I understand that no practitioner under Castle Rock Bioenergetic and Natural Medicine is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider. I am at liberty to seek or continue medical care from a licensed health care provider of my choosing. Any treatment or advice provided to me as a client is not mutually exclusive from any treatment or advice that I may currently be receiving (now or in the future), from a licensed health care provider.

Initials_____

**Medical Information Release Form
(HIPPA Release Form)**

Name: _____

Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: _____

Children: _____

Other: _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call (circle)

My home: _____ My work: _____ My cell number: _____

If unable to reach me: (circle)

You may leave a detailed message

Please leave a message asking me to return your call

Other _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____