

Simple Medical History

Name			
Date of birth:		Age:	
Address:			
email:			
Home phone:		Work phone:	
Cell phone:			

Current Medications	Medication Allergies

Food Allergies		Any Other Allergies

Any complications your mother's pregnancy	Any complications during your delivery

Illnesses or Injuries in first 5 years	Hospitalizations in first 5 years

Any car accidents, and/or any incidents of coma/loss of consciousness at any time

Name:		Phone:	
Email:		Date:	
<i>Please take a moment to check off any that you seem to struggle with currently. Two checks if major issue/.</i>			
<input type="checkbox"/>	Anger Issues	<input type="checkbox"/>	Dreams
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Fear
<input type="checkbox"/>	Authority Issues	<input type="checkbox"/>	Frustration
<input type="checkbox"/>	Blocked Creativity	<input type="checkbox"/>	Guilt or shame
<input type="checkbox"/>	Boundaries	<input type="checkbox"/>	Grief or sorrow
<input type="checkbox"/>	Career Issues	<input type="checkbox"/>	High stress
<input type="checkbox"/>	Compulsive behaviors	<input type="checkbox"/>	Immune system
<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Indecisive or indifferent
<input type="checkbox"/>	Connection	<input type="checkbox"/>	Learning Issues
<input type="checkbox"/>	Control Issues	<input type="checkbox"/>	Low self esteem
<input type="checkbox"/>	Decision making	<input type="checkbox"/>	Analytical circle thinking
<input type="checkbox"/>	Denial or avoidance	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Motivation
<input type="checkbox"/>		<input type="checkbox"/>	Negative self talk
<input type="checkbox"/>		<input type="checkbox"/>	Organization
<input type="checkbox"/>		<input type="checkbox"/>	Panic
<input type="checkbox"/>		<input type="checkbox"/>	Perfectionism
<input type="checkbox"/>		<input type="checkbox"/>	Procrastination
<input type="checkbox"/>		<input type="checkbox"/>	Rejection
<input type="checkbox"/>		<input type="checkbox"/>	Relationship Issues
<input type="checkbox"/>		<input type="checkbox"/>	Self Sabotage
<input type="checkbox"/>		<input type="checkbox"/>	Separation anxiety
<input type="checkbox"/>		<input type="checkbox"/>	Sleep Cycles
<input type="checkbox"/>		<input type="checkbox"/>	Stress
<input type="checkbox"/>		<input type="checkbox"/>	Time Issues
<input type="checkbox"/>		<input type="checkbox"/>	Withdrawal
<i>What brings you in today?</i>			
<i>Please list any medical condition that you would like me to be aware of.</i>			

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: _____

Joy Del Giudice Appointment Cancellation Policy

Your appointment time is important. Missed appointments and late cancellations prevent other people who are in need from receiving timely treatment.

If you need to cancel or reschedule an appointment with Joy Del Giudice, please provide us with at least 48 hours notice. If you do not show for your appointment or you cancel with less than 24 hours notice, you will be charged 100% of the standard appointment fee. If you cancel with less than 48 hours notice, you will be charged 50% of the standard appointment fee.

CANCELLATION FEES

Less than 24 Hours – you pay 100%

24-48 hours notice – you pay 50%

based on business hours

Please note, if you are late for an appointment, your visit may be shortened.

Thank you for helping us to keep appointments available for everyone!

I, _____ (print name),
have read and understand Joy Del Giudice's Appointment Cancellation Policy and
agree to honor it.

Signature of Client or Responsible Party if a Minor

Date

(If Client is a Minor, Print Name of the Client)