ABBA WHOLENESS CENTER

NEW CLIENT INTAKE FORMS

Personal Information

Date: / /

Name: Mr/Mrs/Ms			Birthdate:mm/dd/yy _____ Age:
Address:			Gender: M F Ethnicity:
Email:			Marital Status
Telephone:	(Day)	(Night)	Spouse Name:
If Minor:	Guardian Name:	Phone No.:	Children: Boys___Girls____
Employer	Name: Hrs worked/wk		Position:
Emergency Contact Info:			
Name/Relationship: _____ Phone Number: _____			
Physician Name: _____ Phone Number: _____			

I, ... agree to undergo consultation with ABBA Wholeness Center (AWP) practitioners or other authorized locum, on the following terms:

All personal information gathered from me will be kept confidential under the HIPAA Privacy Law. I agree for information being used, anonymously, for the purpose of advancement of knowledge, for teaching and research. I maintain the right to refuse any examination or treatment that I do not wish to have. I agree that I will make every attempt to comply with any treatment I do accept, or I will discuss the reasons for this with the practitioner or with AWC management.

Abba Wholeness Center, or an authorized locum do not make any medical diagnoses, nor make any claim to "cure" specific diseases. No attempt will be made to interfere with or recommend changes to medical treatment prescribed by a medical doctor.

AWP Practitioners make health assessments according to scientific principles and use holistic methods to assist clients to optimize their health. AWP Practitioners use every care with the quality and appropriateness of therapies and any natural or herbal supplements recommended. I accept that, very rarely, there may be unexpected reactions. In that situation, I accept full responsibility for any adverse reactions and will inform my practitioner at the earliest possible time. I take personal responsibility for my condition, and for the treatment and ongoing maintenance with the support of Abba Wholeness Center, its practitioners and authorized locums. In accordance with legal requirements, I absolve Abba Wholeness Center and its practitioners from adverse reactions arising from non-disclosure of any medication or medical conditions.

Signed:..... Date:.....

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Please fill in this questionnaire so we can establish what your health and wellbeing priorities are. As a holistic practice we see health as a mind-body-spirit issue and the information given here will help your practitioner formulate a specific plan for you to achieve your healthgoals.

Why have you come to Abba Wholeness Center?
What are your goals in consulting with AWC practitioners?

Have you ever had slmllar challenges before, and If so, when?

List any daily activities you are finding difficult, or are limited as a result of this issue(s):

Please list any other healthcare professionals you are seeing for this or other problem(s). Please give their names and modality:
Please list any medical tests or scans you have had in the last 12 months:

List any prescribed medication that you are currently taking or have taken regularly in the past:
List any natural dietary supplements that you are currently taking or have taken regularly in the past:

Past medical history (previous injuries, accidents, surgeries, traumas, loss of consciousness, child-hood illnesses, etc. Please describe and include approximate dates: *(Use back if needed)*

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Do you or your family members (eg parent or sibling) have a history of (please circle) :
Mental Illness Addiction Cancer PTSD
Emotional Traumas Heart Disease Diabetes Arthritis Astma/Eczema
Relationship Conflict/Divorce Adoption

:

What would you consider your outlook in life? Religious Spiritual Agnostic Atheist
Do you have any Religious Affiliation?

Men's Health						
How many times do you get up at night to urinate?	0	1	2	3	4	more
Is urination painful?	Yes	No				

Women's Health	Menstrual Cycle: Regular every_____days	Irregular
Do you get PMT?	Always	Sometimes Never
What type of contraception do you use?		
About Menopause are you:	Pre	Peri Post

How do you rate your sleep on scale 1 - 10?	(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Do you suffer ongoing depression?	(mild) 1 2 3 4 5 6 7 8 9 10 (severe)
How do you rate your energy on scale 1 - 10?	(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Are you continually tired and underpar?	(never) 1 2 3 4 5 6 7 8 9 10 (severe)

What do you do to relax, ie hobbies, meditation, etc?		
How much time do you have for yourself to relax?	hrs/week	When?

What kind of exercise do you do?
How long do you spend per day? hrs
How many times per week do you do this?

Please mark best descrlptlon for level of stress

Family stress: None Minimal Moderate Severe

Relationship stress: None Minimal Moderate Severe

Work stress: None Minimal Moderate Severe ss:

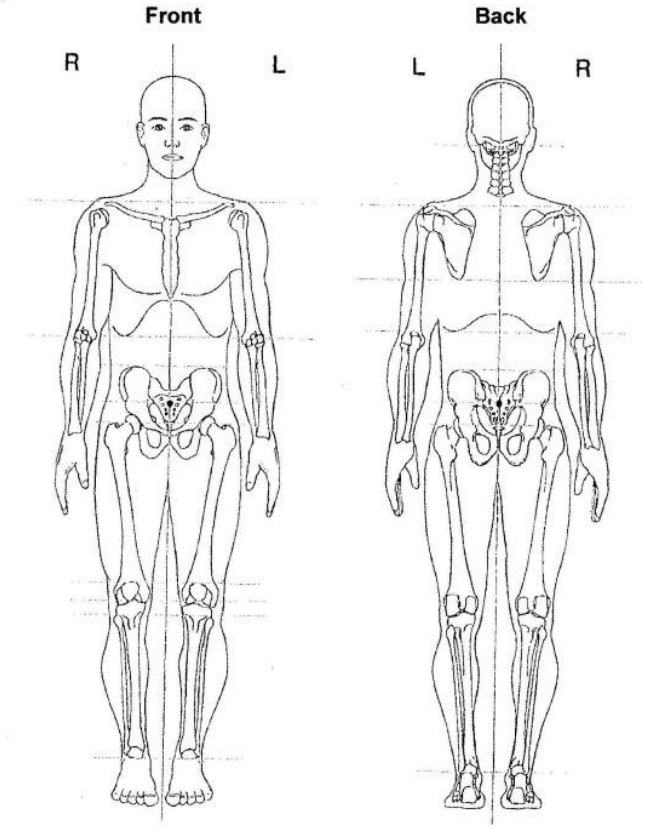
Financial stre None Minimal Moderate Severe

Health stres : None Minimal Moderate Severe s:

Other Stres None Minimal Moderate Severe

19. On the diagram below please mark any area and level of pain or discomfort with a circle using a scale of 1 - 10

1 = Slight awareness of discomfort
2-3 = Awareness of discomfort as an aggravation
4-6 = Pain is strong but you are still functional
7-9 = Pain is so strong you are unable to function normally
10 = Unbearable



Rate any of these feellngs you have ex-perlenced In the last few months on scale 1 (not at all) to 5 (extreme)

Abused	1	2	3	4	5
Criticized	1	2	3	4	5
Overworked	1	2	3	4	5
Paralysed	1	2	3	4	5
Depressed	1	2	3	4	5
Rejected	1	2	3	4	5
Despaired	1	2	3	4	5
Helpless	1	2	3	4	5
Hopeless	1	2	3	4	5
Paranoid	1	2	3	4	5
Overwhelmed	1	2	3	4	5
Muddled	1	2	3	4	5
Persecuted	1	2	3	4	5
Guilty	1	2	3	4	5
Easily irritated	1	2	3	4	5
Anxious	1	2	3	4	5
Sad	1	2	3	4	5
Grieving	1	2	3	4	5
Unable to grieve	1	2	3	4	5
Apprehensive	1	2	3	4	5
Agitated	1	2	3	4	5
Uneasy	1	2	3	4	5
Distressed	1	2	3	4	5
Fearful	1	2	3	4	5
Impatient	1	2	3	4	5
Intimidated	1	2	3	4	5
Restless	1	2	3	4	5
Panic	1	2	3	4	5
Intolerant	1	2	3	4	5
Uncertainty	1	2	3	4	5
Aggravated	1	2	3	4	5
Annoyed	1	2	3	4	5
Angry	1	2	3	4	5
Outraged	1	2	3	4	5
Nervous	1	2	3	4	5
Worried	1	2	3	4	5

Your Current Diet

Breakfast: (specify if missed and no. of times missed/wk)

Morning Snack:

Lunch:

Afternoon Snack

Dinner:

Late night snack (if any)

Please indicate amounts of the following per day / week if taken:

Coffee:

Soft Drinks / Energy drinks (please specify): Alcohol:

Marijuana:

Chocolate:

Sugary Snacks / lollies / junk food:

Cigarettes: (specify if e-cigarette)

Quantity of PURE water drunk daily (if at all)**:**

Deep fried foods:

Stir fried foods:

Red meats:

White meats:

Fish meals:

Vegetarian meal

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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)**

1. Authorization

I authorize **ABBA WHOLENESS CENTER, LLC** to use and disclose the protected health information described below to:

SPOUSE : _____

CHILDREN: _____

OTHERS: _____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____. **OR**

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record with the exception

of the following information: □ Mental health records

□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative
Printed name of patient or personal representative and his or her relationship to patient Date

_____

Signature of Participant or Personal Representative

_____

Date

_____

Printed Name of Participant or Personal Representative

_____

Description of Personal Representative's Authority