Mary Ellen Moore, CCHt, VCSW, BCT

Date:_____

Name:_____

What do you like to be called: _____

Date of Birth:_____ Age: _____ Sex: F____ M____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: Home: _____ Cell:_____ Work:_____

E-Mail Address:_____

Occupation:_____ SS#: _____

Healthcare Provider:_____

Do you visit your doctor regularly: _____ For what? _____

Please list all medical conditions you have _____

_____

Please list all medications that you take _____

_____

Drug Allergies:_____

How did you hear about me? Friend/Family(who)_____

Internet:_____ Yellow Pages:_____ Other:_____

By signing this form I give me consent to receive treatments from Mary Ellen Moore including craniosacral, hypnotherapy and Core Transformation. I understand I may discontinue the session at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. My information may be shared among practitioners at Synergy. I have stated all medical conditions that I am aware of and will update the therapist(s) of any changes in my health status.

Signature:_____ **Date:**_____

SYNERGY Holistic Health Center
7413 US Hwy 42, Suite 3, Florence, KY 41042
859~525~5000

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Please mark if you have had any of these conditions
(please include the date that the condition occurred)

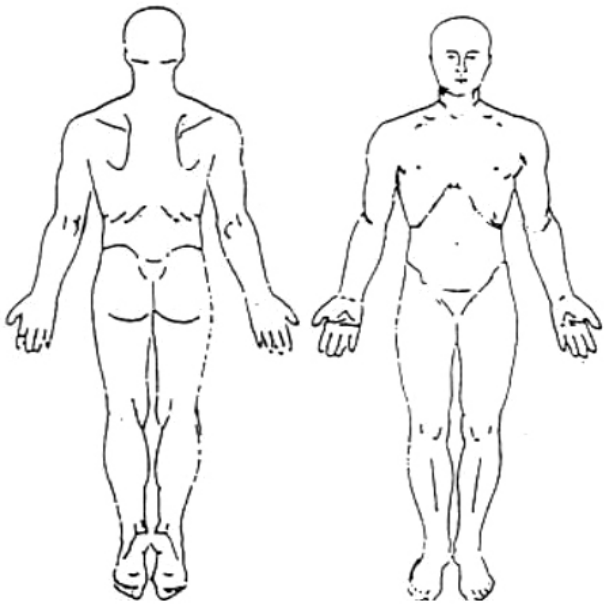
_____ Broken Bones	_____ Kidney disease
_____ Epilepsy	_____ Hepatitis
_____ High/Low Blood Pressure	_____ Headaches
_____ Diabetes	_____ Numbness in Extremities
_____ Heart Disease	_____ Respiratory Disorders
_____ Arthritis/Osteoporosis	_____ Fatigue
_____ Back Pain/Problems	_____ Anxiety
_____ Allergies/Sinus Problems	_____ Neck Pain/Problems
_____ Mood Swings	_____ Tuberculosis
_____ Thyroid Disorders	_____ Aneurysm
_____ Phebitis (blood clots)	_____ Skin condition

_____ Cancer Type_____
_____ Aids/HIV Treatment_____
_____ Pregnant Due Date_____

Please list any surgeries (within the last 2 years) _____
_____
_____

What brings you here today?_____

Please circle problem areas.



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Check all that apply and rate the level of pain experienced (1 is the least, 10 is the most)
I experience pain:

	Daily	Weekly	Occasionally (When?)	
Ankles	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Arms	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Back	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Feet	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hands	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Head	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hips	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Joints	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Legs	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Muscles	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Neck	____	_____	_____	1 2 3 4 5 6 7 8 9 10
Other	____	_____	_____	1 2 3 4 5 6 7 8 9 10

Have you ever participated in or received

	Daily	Weekly	Occasionally	When or Where
Guided Imagery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Hypnotherapy	_____	_____	_____	_____
Meditation	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Breathwork	_____	_____	_____	_____
Craniosacral	_____	_____	_____	_____
Energy Work	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Tai Chi	_____	_____	_____	_____
Yoga	_____	_____	_____	_____

Please describe what you are here for: _____

_____

_____

_____

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