CARRIE W. BODANE, LMBT
Minister of Soulful Living
Center for Healing Transformation
4109 Wake Forest Rd., Ste 303, Raleigh, NC 27609
919/874-0060

Confidential Health History Form

Please print and fill out this form and bring to your first session. Carrie looks forward to assisting you!

DATE: ______________________________

NAME __________________________________HOME # _______________ WORK # _____________ MOBILE#______________

ADDRESS ____ CITY ___________________ STATE _______ ZIP_______________

DATE OF BIRTH _______________ AGE ______ M ____ F ____ MARITAL STATUS ___________________________________

OCCUPATION ________________________________ REFERRED BY ____

EMAIL ADDRESS _____ ____

HAVE YOU IN THE PAST RECEIVED ALTERNATIVE, SPIRITUAL, OR PSYCHOLOGICAL THERAPIES? PLEASE LIST:

____

____

PLEASE LIST THE THERAPIES YOU ARE CURRENTLY RECEIVING: ____

____

____

ARE YOU CURRENTLY TAKING ANTI-DEPRESSANTS OR RECEIVING PSYCHOLOGICAL THERAPY? ______________

WHEN? ______________________ BRIEFLY EXPLAIN: ____

LIST MEDICATIONS AND NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING & REASON FOR USE:

_____________________ _______________________________ PRESCRIPTION BEGAN _______ TAKEN: DAILY ___ AS NEEDED ___
MEDICATION REASON

_____________________ _______________________________ PRESCRIPTION BEGAN _______ TAKEN: DAILY ___ AS NEEDED ___
MEDICATION REASON

_____________________ _______________________________ PRESCRIPTION BEGAN _______ TAKE N: DAILY ___ AS NEEDED ___
MEDICATION REASON

_____________________ _______________________________ PRESCRIPTION BEGAN _______ TAKEN: DAILY ___ AS NEEDED ___
MEDICATION REASON

_____________________ _______________________________ PRESCRIPTION BEGAN _______ TAKE N: DAILY ___ AS NEEDED ___
MEDICATION REASON

DO YOU HAVE A PERSONAL HEALTH HISTORY OF THE FOLLOWING?

__ TMJ
__ NECK PAIN
__ WHIPLASH
__ HEADACHES
__ DISK PROBLEMS
__ LOW BACK PAIN
__ M ID BACK PAIN
__ SCOLIOSIS
__ IRRITABLE BOWEL

___ EDEMA
___ SEIZURES
___ABDOMINAL PAIN
___ PHLEBITIS
___ ARTHRITIS, BURSITIS
___ STROKE
___ CURRENT SPRAINS
___ HIV/AIDS
___ WEAR CONTACTS

___BREAST AUGMENTATION
___ DIABETES
___ VARICOSE VEINS
___ HIGH BP
___ GOUT
___ DIVERTICULITIS
___ ADD/LEARNING DISABILITIES
___ CHRONIC PAIN

___ CANCER (PLEASE DESCRIBE BELOW)
___ SWELLING OF BRAIN
___ BRAIN HEMORRAGE
___ DEPRESSION
___ BIPOLAR DEPRESSION
___ NERVOUS TENSION
___ ANXIETY DISORDER
___ HORMONE DISORDERS

LIST FOOD AND ENVIRONMENTAL ALLERGIES/INTOLERLENCES: ____

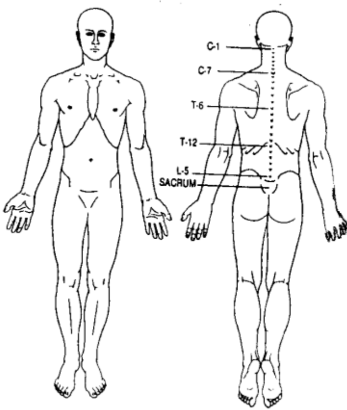
____

OTHER ____

PLEASE DATE & DESCRIBE ALL MAJOR ACCIDENTS & SURGERIES YOU HAVE EXPERIENCED:

1)____
2)____
3)____
4) ____

CIRCLE AND MARK WITH THE APPROPRIATE NUMBER WHERE YOU ARE EXPERIENCING PHYSICAL PAIN OR IMBALANCE, WITH THE NUMBERS 1 THROUGH 10 (1=BARELY NOTICEABLE, 5 = MODERATE, 10= EXTREME)



PLEASE SHARE MAJOR STRESSES THAT ARE OCCURING IN YOUR LIFE : ______________________ ____
____

WHAT HEALTH OUTCOME WOULD YOU LIKE TO RECEIVE FROM OUR SESSIONS?

____
____
____
____

PLEASE DESCRIBE YOUR SPIRITUAL GOALS YOU WOULD LIKE ASSISTANCE WITH:

____
____
____

I acknowledge that the above information is complete and accurate and I will inform Carrie Bodane of any medical changes and changes in medications. I understand that services received by Carrie Bodane, LMBT, MSL are not a replacement for medical care and that no diagnosis will be made.

I understand that by providing this informed consent I am assuming full responsibility for my session and I hold harmless Carrie Bodane and the facility/location where the session is provided.

Dated: ___________________ Signature: ____