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**Avalon Gulley, BCST, PLC**

**Confidential Client Intake Form and Release of Liability**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Here are some questions regarding your physical, emotional and mental health.**

**Please answer the questions you feel comfortable answering.**

What are the problem(s) for which you are seeking help?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your goals in our work together?

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Are you under the supervision of a physician for any health concerns? ( ) Yes ( ) No
If yes, for what?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current medications? ( ) Yes ( ) No

 If yes, which? For what?

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**Symptoms Checklist (Write X for Current, P for Past, and C for Chronic):**

**Physical:**

* **Pain**
* **Tension**
* **Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Fatigue**
* **Insomnia/Difficulty Sleeping**
* **Changes in Appetite or Weight**
* **Digestive Problems/Gut Issues**
* **Migraines/Headaches**
* **Arthritis**
* **Asthma**
* **Coronary Artery Disease**
* **Alzheimer’s**
* **Kidney Disease**
* **Liver Disease**
* **Thyroid Disorder**
* **Obesity**
* **Lyme’s Disease**
* **Neurological Problems**
* **Osteoporosis**
* **Libido Concerns**
* **Diabetes**
* **COPD (Chronic Obstructive Pulmonary Disease)**
* **Epilepsy/Seizures**
* **Fibromyalgia**
* **High/Low Blood Pressure**
* **High Cholesterol**
* **Stroke**
* **Vertigo**
* **TMJ**
* **Cancer**
* **Reproductive Health Concerns**
* **Menstruation Issues**
* **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emotional:**

* **Stress**
* **Trauma**
* **Persistent Sadness**
* **Feeling Hopeless**
* **Anxiety**
* **Excessive Worry**
* **Panic**
* **Depression**
* **Feelings of Guilt/Shame**
* **Impulsivity**
* **PMS (Premenstrual ‘Syndrome’)**
* **Irritability**
* **Crying spells**
* **Feeling Worthless**
* **Isolation/Social Withdrawal**
* **Euphoria**
* **Risk-Taking**
* **Abuse (Physical/Emotional/Sexual/Psychological or Spiritual)**
* **Grief**
* **Anger/Rage**

**Mental:**

* **Racing Thoughts**
* **Self-Criticism**
* **Thoughts of Self-Harm**
* **Obsessions or Compulsions**
* **Procrastination**
* **Inability to Focus (Concentrate)**
* **Difficulty Making Decisions**
* **Addiction (of any kind, including: alcohol, food, sex, gambling, shopping, etc)**
* **Schizophrenia**
* **Bipolar Disorder**
* **Flashbacks**
* **PTSD**
* **Nightmares**
* **Hallucinations or Delusions**
* **Phobias**

What medical history would you like me to be aware of, including: **surgeries, injuries, accidents, falls, illness, disease, mental health, addiction or trauma**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What **family** medical or trauma history would you like me to be aware of?

**Substance Use Checklist: (Write X for Current, P for Past, and C for Chronic)**

* **Caffeine (Coffee, Soda, Tea)**
* **Tobacco**
* **Alcohol**
* **Cigarettes**
* **Marijuana**
* **Other Substances: \_\_\_\_\_\_\_\_**

**Current Health Care Modalities: (Write X if Yes)**

* **Counseling**
* **Massage Therapy**
* **Physical Therapy**
* **Bodywork**
* **Chiropractic**
* **Acupuncture/Chinese Medicine**
* **Nutrition**
* **Homeopathy**
* **Other: \_\_\_\_\_\_\_\_\_**

**Spiritual Life:**

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Please note that this practice is not associated with any religion or spiritual group and uses non-religious language and concepts*

**Is there anything else that you would like me to know?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Scope of This Practice and Client Waiver Form**

The two modalities utilized in this practice are: 1) Biodynamic Craniosacral Therapy - a gentle, hands-on method which inspires health and healing, including the nervous system, tissues, fascia, fluids and skeletal structure of the body; and 2) Polarity Life Coaching -techniques which bring energy, movement and flow to areas of the body and mind which may be stuck in fixation. Both modalities are received fully clothed.

***Please take a moment to read and initial each of the following statements:***

Avalon Gulley, BCST, PLC is an insured Biodynamic Craniosacral Therapist and Polarity Life Coach. If during the course of our work, Avalon feels circumstances arising that are beyond the scope of her parameters, she will suggest you see an appropriate professional, either in place of, or as an adjunct to our work. \_\_\_\_\_\_\_\_

You can be assured that any information shared during a session will remain strictly confidential as required by law. \_\_\_\_\_\_\_\_

I understand that the services offered today are not a substitute for medical care. I understand that Avalon is not qualified to make diagnoses or prescribe medication. \_\_\_\_\_\_\_\_

I affirm that I have notified Avalon of all known medical conditions and injuries.

I understand that there shall be no liability on Avalon’s part should I fail to do so. \_\_\_\_\_\_\_\_

I understand that Avalon’s services are entirely therapeutic and non-sexual in nature. \_\_\_\_\_\_\_\_

It is my responsibility as a client to inform Avalon of any discomfort. \_\_\_\_\_\_\_\_

By signing this release, I hereby waive and release Avalon Gulley, BCST, PLC and Avalon Integrative Care from any and all liability, past, present, and future relating to the session work.

\_\_\_\_\_\_\_\_

**I agree to abstain from drinking alcohol, using marijuana or other drugs within 24 hours of our appointment. I understand that if I show up to my appointment under the influence of alcohol, marijuana or drugs, my appointment will be canceled and no refund will be given. \_\_\_\_\_\_**

I agree to seek out a licensed professional therapist or medical professional if I am having suicidal thoughts or ideations. I acknowledge that suicidal thoughts or ideations are beyond the scope of this practice. \_\_\_\_\_\_\_

I will make every effort to notify Avalon by text, phone or schedule app, if I cannot make a scheduled appointment. I understand that if I cancel my appointment within 24 hours of appointment time or if I “no show” for an appointment, I will be charged the full amount and will not receive a refund. \_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

I, the practitioner, agree to perform my duties to the best of my ability keeping client health, safety, well-being and satisfaction foremost in mind. I will keep all client information and details in strict confidence as indicated by law and good ethical practice.

Practitioner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_