*Please complete this form prior to our first appointment. If possible, email it to me at*

*mcgovernfitness@gmail.com* *before our appointment or print it and bring it to your first*

*appointment.*

***Provide as much information as you feel comfortable.***

|  |
| --- |
| **General Information** |
| **Name:** | **Age:**  | **Birthdate:** |
| **Street Address:** | **City:** | **Zip:** |
| **Email:** | **Phone:** |
| **Emergency Contact (name, relationship, phone number):** |

|  |
| --- |
| **Starting Sessions** |

What are the central issues in your life at this time?

Describe what you hope to accomplish in our work together:

|  |
| --- |
| **Therapy History** |

Have you been in counseling for this or other concerns in the past? Yes ☐ No ☐

If yes, briefly describe:

Would you consider seeing a counselor or therapist is anything arises during a BBTR session where their expertise and support could be of assistance to you? Yes ☐ No ☐

|  |
| --- |
| **Family Details** |

Number of siblings in your family:

What number are you in the birth order of your siblings?

Current relationship status of your parents:

If parents divorced, split up, or separated, at what age were you when this happened?

Were you adopted? Yes ☐ No ☐ If yes, at what age and under what circumstances?

As far as you know, did your mother or you experience difficulties during her pregnancy, labor, or shortly after your birth? Yes ☐ No ☐ If yes, please explain:

|  |
| --- |
| **Personal Medical and Mental Health History** |
|  | **me past** | **me current** |  | **me past** | **me current** |  | **me past** | **me current** |
| Allergies | **☐** | **☐** | Fibromyalgia | **☐** | **☐** | Glaucoma | **☐** | **☐** |
| Asthma | **☐** | **☐** | Scoliosis | **☐** | **☐** | ADD/ADHD | **☐** | **☐** |
| Eczema | **☐** | **☐** | Self-Harm | **☐** | **☐** | Crohn’s Disease | **☐** | **☐** |
| Migraine | **☐** | **☐** | Osteoporosis | **☐** | **☐** | Cancer | **☐** | **☐** |
| Pregnancy | **☐** | **☐** | Epilepsy or seizures | **☐** | **☐** | Arthritis | **☐** | **☐** |
| Stroke | **☐** | **☐** | Learning Disability | **☐** | **☐** | Heart Disease | **☐** | **☐** |
| Sexual Problems | **☐** | **☐** | Thyroid Disease | **☐** | **☐** | Eating Disorder | **☐** | **☐** |
| Anxiety | **☐** | **☐** | Depression | **☐** | **☐** | Phobias | **☐** | **☐** |
| Bipolar | **☐** | **☐** | Panic Attacks | **☐** | **☐** | Suicidal | **☐** | **☐** |
| Irritable Bowel Syndrome | **☐** | **☐** | Borderline Personality Disorder | **☐** | **☐** | Obsessive/ Compulsive (OCD) | **☐** | **☐** |
| Chronic Fatigue Syndrome | **☐** | **☐** | High Blood Pressure | **☐** | **☐** | Digestive Problems/GERD | **☐** | **☐** |
| Lime Disease | **☐** | **☐** |  |  |  |  |  |  |
| Any other conditions not listed above: |

Please list any surgeries you’ve had and their dates:

Current prescription medications:

Current supplements taken:

|  |
| --- |
| **Lifestyle** |

**Screen Time**

Number of hours of screen time per day (phone + computer + video games + TV)?

Do you find it hard/impossible to be away from your devices**?** Yes ☐ No ☐ Unsure ☐

**Substance Use Currently or In Past**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Regarding Current Use** | **Regarding Past Use** |
|  | **I currently use** | **my use is interfering with my life** | **I feel the need to cut down on use** | **my use interfered with my life in the past** | **I felt the need to cut down on my use in the past** |
| **Tobacco** | **☐** | **☐** | **☐** | **☐** | **☐** |
| **Alcohol** | **☐** | **☐** | **☐** | **☐** | **☐** |
| **Recreational Drugs** | **☐** | **☐** | **☐** | **☐** | **☐** |
| **Caffeine** | **☐** | **☐** | **☐** | **☐** | **☐** |
| **Sugar** | **☐** | **☐** | **☐** | **☐** | **☐** |

**Sleep**

Hours of sleep on average per night:

Quality of sleep:

How you awake**:**

Do you struggle with insomnia? Yes ☐ No ☐ If yes, what methods have you tried to address your difficulty sleeping and are they working?

Do you currently or in the past have or had a meditation practice? Yes ☐ No ☐ If yes, please describe your current practice or why you no longer practice.

**Body**

Have you ever had a professional massage? Yes ☐ No ☐ If yes, did you or do you enjoy massage? Yes ☐ No ☐ Are you sensitive to touch or pressure in area of the body? Yes ☐ No ☐ If yes, please explain

Is there a particular area of the body you experience tension, stiffness, pain or other discomfort? Yes ☐ No ☐

If yes, please explain

**Physical Activity and Energy Level**

What do you do for physical activity and with what frequency?

On a scale of 0 to 10, what is your current energy level (0=completely drained; 10= very energetic)?

**Stress**

On a scale of 0 to 10, what is your current overall stress level (0 = none; 10= stressed to the max)?

Biggest sources of stress in life currently:

How do symptoms of stress show up in your body?

How do you typically cope with stress?

**Relaxation, Joy, and Support**

What activities recharge your batteries?

What/who are the biggest sources of joy in your life?

Who do you rely on for emotional support in your life?

|  |
| --- |
| **Adverse Events in Childhood** |
| ***While I was growing up, during my first 18 years of life….*** | **Yes** | **No** | **If yes, how much did this experience bother you at the time?** | **If yes, how much does this bother you now?** |
| **0=not at all to 5= very much** | **0=not at all to 5= very much** |
| I experienced **physical abuse** (e.g., pushed, grabbed, slapped, beaten, or harshly punished) from a parent or other person. | **☐** | **☐** |  |  |
| I experienced **sexual abuse** (e.g., touching, molesting, fondling, or intercourse) from a parent or other person. | **☐** | **☐** |  |  |
| I experienced **emotional abuse** (e.g., humiliation, threats, boundary violations, blame, bullying) from a parent or other person. | **☐** | **☐** |  |  |
| I experienced **neglect** (e.g., real or threatened abandonment, failure to provide essentials) from a parent. | **☐** | **☐** |  |  |
| I witnessed family members suffering from physical, sexual, or emotional abuse. | **☐** | **☐** |  |  |
| My parents separated or divorced. | **☐** | **☐** |  |  |
| A parent, sibling, or other important person in my life died. | **☐** | **☐** |  |  |
| A parent or other adult in my home was an alcoholic or drug addict. | **☐** | **☐** |  |  |
| A parent or other adult in my home was depressed, mentally ill, or suicidal. | **☐** | **☐** |  |  |
| I experienced discrimination because of my race, gender, appearance, sexual orientation, religion, or other factors. | **☐** | **☐** |  |  |

Other childhood difficulties that are not captured above:

|  |
| --- |
| **Adverse Events in Childhood** |

Have you faced significant challenges as an adult (e.g., serious illnesses, accidents, losses, adult trauma, abusive or unstable relationships)? Yes ☐ No ☐If yes, briefly describe:

|  |
| --- |
| **Did I Miss Anything?** |

Is there any other information you would like me to know about you at this time that isn’t captured above?

Yes ☐ No ☐ If yes, please describe

|  |
| --- |
| **Disclosure Form and Agreements** |
|  | **check if you agree** |
| I understand during breathwork, touch may be used to help facilitate greater body awareness, support the development of emotional resources and release of traumatic stress. I can refuse touch at any time. | **☐** |
| If I am unable to keep an appointment, I will notify Sueat least **24 hours in advance**. I understand that I will be charged a regular *full session fee* for scheduled sessions if I don’t show up for or call/email to cancel with appropriate notice. | **☐** |
| I understand that BioDynamic Breath and Trauma Release System® includes physical movement, breath, meditation, release of emotions, touch and bodywork and sound. I understand BBTRS® gives an opportunity for release of chronic muscular tension and free flow of energy in the body. | **☐** |
| As is the case with any physical activity, the risk of injury, even serious disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, discontinue the activity, and ask for support from the facilitator. I will continue to breathe smoothly. I assume full responsibility for any and all damages, which may incur through participation.  | **☐** |
| I understand that the breathing facilitator does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals. | **☐** |
| I understand that BBTRS® is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. | **☐** |
| BBTRS® is not recommended and is not safe under certain medical conditions. I will make the facilitator aware of any medical conditions of physical limitations before the session. I confirm that I am not pregnant, nor have severe heart disease, mental illness, epilepsy/history of seizures, aneurisms, severe diabetes, or acute physical injuries. I am not intoxicated by alcohol or drugs. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in a BBTRS® session. | **☐** |
| I also affirm that I alone am responsible for deciding whether to participate in a BBTRS® session and that participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against my breathing facilitator | **☐** |
| I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability to the greatest extent allowed by law in the State of Illinois.  | **☐** |

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**Signature** **Date**