Brandon Chasse, MA – HeartMath Coach

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Intake Information and History

This is a CONFIDENTIAL questionnaire to help me determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Place an * by any question you're not comfortable addressing in writing and we'll discuss them in your initial session.

Date: _____ Name: _____

Address: _____

Email Address:_____

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

Age: _____ Date of Birth (mm/dd/yyyy): _____

Emergency Contact (*EC*) Name: _____ *EC* Relationship: _____

EC Phone: _____ *EC* Address: _____

Occupation: _____ Employer: _____

Military Service? YES or NO Dates: _____ Combat? YES or NO

Ethnicity/heritage: _____ Religious/spiritual affiliation: _____

With whom do you live? _____ Relationship/Marital Status: _____

Do you have children? YES or NO If so, how many and their ages: _____

What is your primary reason/concern for seeking HeartMath? _____

_____

_____

What are some of the major stressors in your life? _____

_____

_____

Treatment and Medical History

Are you currently receiving, or have you previously received, services from a health professional (i.e., physician, psychiatrist, therapist, life coach, nutritionist, etc.)? YES or NO

Is your health professional a member of Optimal You? YES or NO

If you are currently seeing a health professional, please list the provider's name and phone number:

Provider: _____ Phone Number: _____

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Provider: _____ Phone Number: _____

** Do you give permission for me to share information from your HeartMath sessions with your health professional so we can work collaboratively in your treatment? YES or NO

What other forms of treatment have you sought: _____

_____

Have you ever been hospitalized for psychiatric or drug/alcohol treatment? YES or NO

If yes, please describe the circumstances, including length of hospitalization and dates: _____

_____

Please list any medications you are currently taking: _____

_____

Please list any herbal supplements or other non-prescribed medications you are currently taking: _____

_____

Please indicate the daily servings of the following:

Coffee: _____ Soda pop: _____ Water: _____ Alcohol: _____ Tobacco: _____

Are there any health problems in particular for which you are seeking treatment? _____

_____

How long have you had this condition: _____

Please indicate if any of the following pertain to you: (marking any of the following does not make you ineligible for treatment, however, it may alter some of the treatment modalities):

□ High Blood Pressure □ Alexithymia □ Pacemaker □ Insomnia □ Depression □ Anxiety

□ Headaches (tension type and migraines) □ Cardiovascular rehab □ ADD/ADHD □ Addictions

□ Performance/Test Anxiety □ Asthma □ Chronic Pain □ Chronic fatigue □ Environmental sensitivity

□ Fibromyalgia □ Cancer □ Tics/Tourette's syndrome □ Traumatic brain injury □ Arthritis

□ Phantom pain and amputation □ PTSD □ Atropic dermatitis □ Diabetes Type I and II □ Autism

□ Hypertension □ Inflammatory bowel disease (Crohn's disease and ulcerative colitis) □ Muscle spasticity

□ Immune-system dysfunction □ Reflex sympathetic dystrophy (complex regional pain syndrome)

□ OCD □ Congestive Heart Failure □ Abdominal Pain □ Loss and Grief □ Eating Disorders

Please add anything else you would like me to know about you at this time: _____

_____

_____

_____

_____

_____

_____

_____

By signing on this document, you are acknowledging that all information written within this document is true: _____