

Brain Works Naturally

Connect Heart + Brain + Body



23 Edgecomb Road
Binghamton, NY 13905
Phone: (607) 797-9357

Date: _____ Have you ever been here before? Yes No

Date of Birth: _____ Age: _____ Home phone: (____) _____

Name: _____ Cell phone: (____) _____

Street Address: _____

City, State, ZIP: _____

Email: _____

Occupation: _____ Business Phone: (____) _____

Male / Female Height _____ Weight _____

Referred By: _____

Do you have a pacemaker? Yes No Do you have uncontrolled hypertension? Yes No

Have you ever had any of the following?

___ Far Infra-Red Sauna ___ Chi Machine ___ Cold Laser Therapy ___ BioCharger ___ Sound Therapy ___ Listening Program

___ Detox Footbath ___ Reflexology ___ Aromatherapy ___ E-Power ___ Vital Life Pro ___ Brain Gym

___ Biosonic Tuning ___ Aroma Dome ___ Aroma Freedom ___ Electro-reflex ___ Emotion Code ___ Touch For Health

___ Reiki ___ Raindrop ___ Primitive Reflex Therapy ___ HeartPartner ___ Vivalign Energy Screening

Waiver Release

I, _____, understand that Janice Fiore is not a Doctor, and that the services provided do not in any way diagnose, prescribe, or treat a specific condition or disease. Services provided here are intended to enhance health by facilitating balance in the mind/body systems and to relieve tension, interrupt the stress response, which in turn helps to improve nerve and blood supply and to normalize the body.

Signature: _____ Date: _____

Name: _____

Date: _____

IF YOU EXPERIENCE ANY OF THE FOLLOWING, PLEASE CHECK:

Arthritis ___ Asthma ___ Colitis ___ Diabetes ___ Diverticulitis ___ Ulcers ___ Kidney Problems ___

Fatigue ___ High Blood Pressure ___ Hemorrhoids ___ Constipation ___ Water Restriction ___

Bad Breath ___ Headaches ___ Indigestion ___ Other _____

Allergies _____ Cancer/Type _____

Surgeries/Broken bones

explain: _____

DO YOU USE ANY OF THE FOLLOWING?

Alcohol _____ drinks / week

Tobacco _____ packs/day

OTC Medications _____

Prescriptions: _____

Are you under a doctor's care/explain: _____

Doctor's name/phone number _____

Name: _____

Date: _____

DIET AND NUTRITION

<i>How often do you use the following? (1-Daily, 2-Weekly, 3-Occasionally, 4-Never)</i>																
<i>Red Meat</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Fruits/Veggies</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Fast Foods</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>		
<i>Refined Sugar</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>White Flour</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Fried Foods</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>		
<i>Dairy Foods</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Soda</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Alcohol</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>		
<i>Snack Foods</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Salted Foods</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>NutraSweet</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>		
<i>Coffee</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Cups day</i>	_____	<i>Tea</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Cups day</i>	_____	<i>Tobacco</i>	<i>Amount</i>	_____
<i>How much water do you drink per day in ounces? _____</i>																
<i>What kind of water do you drink? _____</i>																
<i>List any Nutritional Supplements (with amounts) you are now taking:</i>																

FOOD CHOICES

<i>Do you use organic foods whenever possible?</i>	<i>Yes</i>	<i>No</i>	<i>Are you a vegetarian?</i>	<i>Yes</i>	<i>No</i>
<i>Do you eat meat, i.e. beef, chicken, lamb, etc.</i>	<i>Yes</i>	<i>No</i>			
<i>Do you buy hormone/antibiotic free meats?</i>	<i>Yes</i>	<i>No</i>			
<i>Do you drink milk?</i>	<i>Yes</i>	<i>No</i>			
<i>Circle all that apply to your Dairy Consumption:</i>	<i>Raw</i>	<i>Pasteurized</i>	<i>Organic</i>	<i>Goat Dairy</i>	
<i>Circle products that you consume:</i>	<i>Soy milk</i>	<i>Rice milk</i>	<i>Almond milk</i>	<i>Hemp milk</i>	<i>Other: _____</i>
<i>Do you eat nuts or seeds?</i>	<i>Yes</i>	<i>No</i>	<i>What Type?</i>	_____	
<i>Do you use spices?</i>	<i>Yes</i>	<i>No</i>	<i>Are they organic?</i>	<i>Yes</i>	<i>No</i>
<i>Circle the type of spices that you consume:</i>	<i>Fresh spices</i>	<i>Dried Spices</i>	<i>Jarred Spices</i>	<i>Bulk Spices</i>	<i>Organic Spices</i>
<i>Do you PREFER to home cook your food or go out to a restaurant?</i>			<i>Restaurants</i>	<i>Home</i>	
<i>Do you eat more at restaurants or at home?</i>			<i>Restaurants</i>	<i>Home</i>	
<i>When you go to a restaurant, do you prefer menu style or buffet?</i>			<i>Menu</i>	<i>Buffet</i>	
<i>Would you like to learn how to prepare foods at low temperatures that are fresh and preserve enzymes?</i>	<i>Yes</i>	<i>No</i>			
<i>What types of bread do you eat?</i>	_____				
<i>What types of pasta do you eat?</i>	_____				

GENERAL LIFESTYLE

<i>How much sleep do you get on average? _____ hours per night</i>	<i>Do you feel rested?.....Yes No</i>
<i>How much exercise do you get?</i>	
<i>Exercise _____ min per day _____ days per week Type(s): _____</i>	
<i>Do you experience stress: in your relationships __, at work __, with finances __, in health __, with home __, in trying to have fun __, in being happy __, other _____</i>	
<i>How often do your bowels eliminate?</i>	
<i>What is your energy like?</i>	
<i>Other current health concerns not previously mentioned:</i>	

Medical History

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Name: _____

Date: _____

Please circle all that apply. Put a "P" next to the circle if it is a past medical condition.

Also, please remember to note any medical condition not mentioned on this sheet under other.

Senses Sight Hearing Smell Taste Touch

Skin

Boils	Fungal Infection (Athlete's Foot)	Herpes	
Warts	Eczema	Hives	Moles
			Psoriasis

Respiratory System Bronchitis (490) Sinusitis (J32.9) Asthma (J45.998) Emphysema (J43.9)

Allergies (995.3) _____

Endocrine	Ovarian Cyst (N83.0)	Fibroids	PCOS (E28.2)	Infertility (♂ N46.9 / ♀ N97.9)
Ovaries	Uterus	PMS (N94.3)	Menopause	
(Hypo)Thyroid (E03.9)	Adrenals (E27.9)	Testicles	Prostatitis (N41.9)	Other _____
<u>Diabetes</u>	Type 1 (E10.9)	Type 2 (E11.9)	Hyperglycemia (R73.9)	Hypoglycemia (E16.2)

Immune

Bacterial	Viral	Colds	Flus	Lyme's Disease (A69.20)
Autoimmune	Rheum Arthritis	Epstein Barr (B27.90)	Chronic Fatigue (R53.82)	

Musculoskeletal

Osteopenia (M85.80)	Arthralgia (719.4)	Unspecified	Unspecified
Sprain/Strains	Osteoporosis (M81.0)	Carpal Tunnel (G56.00)	Joint Pain(M25.50)
Herniated Disc (722.2)	Neck Pain (M54.2)	Low Back Pain (M54.5)	Other Pain/Injury _____

Nervous System

Multiple Sclerosis	Parkinson's	Bell's Palsy	Stroke	Spinal Cord Injury
HA 784.0) /Migraine (346)	Numbness	Tingling	Idiopathic pain	

Digestion

Indigestion (K31.9)	Constipation (K59.00)	Diarrhea (R19.7)	Acid reflux (K21.9)	Ulcers (K25.9)
Hx Appendicitis (v12.79)	IBS (K58.94)	Ulcer. Colitis (K51.90)	Hepatitis (573.3)	Gallstones (574)
Food Allergies (995.3): _____			Gall Bl removed (051)	Gall Bladder Dz (K82.9)

Circulatory

Blood Clot (I82.91)				
Anemia (D64.9)	Cardiovascular Dz (I25.10)	Atherosclerosis (I70.90)	High (R03.0)/Low (I95.9) Blood Pressure	
Vericose Veins (I83.10)	Heart Disease (I51.9)	Heart Attack (412)	Edema (R60.9)	High Cholesterol (E78.0)

Cancer

Breast	Ovarian	Testicle	Thyroid	Lung
Blood	Bone	Colon	Bladder	

Stress

	Chronic Stress (F33.9)	Acute Stress Rxn (F43.0)	State of Stress & Shock (R45.7)
Anxiety (F41.1)	Depression 1 (F32.0)	Lack of Sleep (G47.9)	Nightmares (F51.5)

OTHER: _____

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**ATTENDANCE POLICY
RETURNED CHECK FEE POLICY**

Brain Works Naturally (BWN) is in the business of helping people treat their symptoms using holistic options. BWN cannot help you or someone else if you do not show for or cancel your appointment without advanced notice. Therefore, by signing below, you agree to provide 24 hours advance notice in the event the appointment(s) have to be canceled or changed.

If I, the undersigned, do not show up for the appointment, or provide sufficient notification, I agree to pay the full charge for the service, not just for the inconvenience it has caused, but also the loss of income to our therapist who comes in for your appointment. Appointments cancelled less than 24 hours in advance will be charged 50% of the cost of the service. BWN understands that in certain incidences, this is not possible because of emergencies and therefore the charges may be waived at the discretion of management.

Brain Works Naturally accepts cash, credit cards and personal checks for services provided and products purchased. In the event that your personal check is returned by your bank unpaid, you will be assessed a \$ 25.00 returned check fee.

Client

Date