BRIDGE TO WELLNESS GROUP, INC.
A Private Healthcare Membership Association

8504 Precinct Line Rd
Suite 140
Colleyville, TX 76034

Information & History Form

The answers you provide are confidential. Please be as accurate as possible. Please print clearly.

Name:_____ Date of Birth:_____ Age:_____

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

Address:_____ City:_____ State:____ Zip:_____

Height:_____ Weight:_____ Email (*for client communication only*):_____

Who were you referred by?_____ Are you married? _____

Name/Phone of Your Primary Care Physician: _____

Complaints: What are the primary reasons for your visit? (Please rate the severity between 1-10 (10 being worst).

_____

_____

_____

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_____

Wellness Goals: What are your wellness goals? Please list in order of importance to you:

_____

_____

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_____

Therapy Readiness: Improving your health will no doubt require some diet and lifestyle changes. These will be determined from your assessment. Are you prepared to make diet & lifestyle changes to improve your health? _____

On a scale of 1 - 10 (10 being most ready), what score would you rate your therapy readiness? (be completely honest): _____. What type of changes would you be reluctant or unable to make? _____

_____

Medications: Please list all medications you are taking (including all Over the Counter medications), how long you've been taking them, and what they're used for:

Medication	Reason	When Started	Dosage Per Day

Vitamins & Supplements: Please list all vitamin supplements you are currently taking:

_____

_____

_____

_____

_____

Allergies & Sensitivities: Please list all known allergies, including foods, grasses, trees, airborne, chemicals and medications:

_____

_____

_____

Medical Conditions Diagnosed: Have you been diagnosed with any of the following medical conditions (past or present)? If so, put an X in the parenthesis:

( ) Heart Disease
( ) High Blood Pressure
( ) Hepatitis
( ) AIDS or HIV Infection
( ) Whiplash
( ) Depression/Moods
( ) Thyroid Condition
( ) Auto Immune Disease
( ) Neurological Disorders
( ) Epilepsy
( ) Epstein Barr Virus
( ) Herpes Simplex I

( ) Kidney Disorders
( ) Glaucoma or Cataracts
( ) High Cholesterol
( ) Oral - gum/bone problem
( ) Fatty Liver
( ) Bi-Polar Disorder
( ) Stroke
( ) Early Senility
( ) Multiple Sclerosis
( ) Alcoholism
( ) Mononucleosis
( ) Herpes Simplex II

( ) Arthritis
( ) Diabetes
( ) Ulcer
( ) Cancer
( ) Hemorrhoids
( ) Gallstones
( ) Asthma
( ) Pneumonia
( ) Schizophrenia
( ) Concussion
( ) Lyme Disease
( ) Herpes Zoster

( ) Other (please list):_____

_____

Medical, Health & General Background

Smoking: Do you currently smoke?_____ How long have you smoked? _____

Have you ever smoked in the past?_____ For how long?_____

Surgeries: Please list **ALL** major and minor surgeries you've had, including out-patient and in-office procedures *and* Dental surgeries, and list any foreign materials in the body (such as pins, rods, plates, implants):

_____

_____

_____

_____

Vaccinations: Please list all vaccinations you have ever had and when you received them:

_____

_____

Injuries: Please list all injuries (major and minor) you've had and the dates:

_____

_____

_____

_____

Digestion: Please list any digestive problems, including acid reflux, burping, burning/pain in stomach, bloating, nausea, feeling full for too long, colitis, lactose intolerance, Crohn's disease, irritable bowel, spastic colon, diverticulitis, colitis, constipation, diarrhea and any other problems:

_____

_____

Bowel Activity: Please describe your bowel movements, including how often and if you have a complete evacuation daily. List any abnormalities concerning your bowel movements, including unusual color:

_____

_____

Physical Activity: Please describe your activity level. Do you exercise? If so, how often? Are you sedentary for the most part? Do you have a sedentary job? Please describe:

_____

_____-_____

Stress Level: On a scale of 1 to 10 (with 10 being most severe), please list your average stress level, and the cause(s) of your stress:

Level: _____ Cause(s):_____

_____

_____

Diet: Please indicate how many times per week you consume the following foods:

Coffee_____ Sweets_____ Sodas_____ Pork_____ Fast Foods_____ Chips_____

Ice Cream_____ Fried Foods_____ White bread_____ White Pasta_____ Margarine_____

Artificial Sweeteners_____ Grilled/Barbequed Meats_____ Microwaved Foods_____ Sushi_____

Cravings: Please list any food cravings and how often you have them:

_____

_____

Allergies & Sensitivities: Please list all known allergies, including foods, grasses, trees, airborne, chemicals and medications:

_____

_____

_____

Women Only: Are you pregnant?_____ Date of last cycle?_____ Are your periods regular?_____

Have you had any miscarriages?_____+___ Number of pregnancies:_____

Number of abortions:_____ Type of birth control you are using:_____++_____

Do you have recurring vaginal or urinary infections? _____

Do you have cystic breasts?_____ History of breast mass?_____

Men Only: Do you have difficulty urinating, starting urination, or getting up at night to urinate? Describe:

_____

Have you been told you have prostate trouble?_____ Explain:_____

Do you have trouble obtaining or maintaining an erection? Explain:_____

Are you receiving hormone therapy?_____ Explain:_____

Infections: What type of infections have you had in the past? Please indicate if they were chronic, acute or moderate:

_____

_____

_____

Antibiotic use and dates:_____

_____

Have you ever had a blood transfusion? If so, give dates: _____

Childhood Illnesses: Have you had any of the following childhood illnesses?

( ) Earaches ( ) Mumps ( ) Measles ( ) Chickenpox ( ) Inner Ear Infections ( ) Colic

Others:_____

Foreign Travel: List any foreign travel you have done in the last 2 years (place and date):

_____

_____

Traumas: Have you ever experienced:

( ) Rape ( ) Molestation ( ) Attack ( ) Robbery ( ) Incest ( ) Other - Please list any other traumas you've experienced: _____

_____

For Practitioner Use:

Notes: _____

_____

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Authorization and Release Form

Biofeedback testing and Electro-Dermal Screening provide an opportunity to measure electrical responses and meridian flows of the body. Biofeedback and E.D.S. evaluation of the energy flow helps identify various stressors that might impede the electrical processes along the meridians. The evaluation may include recommendations for natural remedies, stress reduction methods, and/or nutritional changes designed to balance the energy meridians and enhance overall wellness. These recommendations are not claimed as cures for any known diseases. The biofeedback and electro-dermal screening assessment is not a method of diagnosing, nor are the suggested remedies designed to replace any of the medications or treatments currently being provided or recommended by your primary care physician.

1. I fully understand that Lisa Setser (hereinafter referred to as the attending consultant) is not an allopathic doctor (MD), and does not pretend to be, but is a traditional naturopath and bio-energetic practitioner providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy.

2. I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy, but is providing information and recommendations for natural products to restore balance and optimum conditions for health and wellness.

3. I fully understand that the attending consultant is not diagnosing or treating any illness or disease, and that if I am seeking a diagnosis of disease, it is my responsibility to pursue this with my Primary Care Physician or other Licensed Medical Doctor.

4. I fully understand that the attending consultant is in no way encouraging me to terminate or modify any previous or ongoing therapies under the direction of any licensed practitioner, and that the attending consultant will not dissuade me from seeking allopathic attention, recommendations or modes of therapy from a licensed physician.

5. I presently seek consultation, advice, opinions and/or programs, test, evaluations, product recommendations within the scope of the attending consultant's wellness practice based upon the principles of bioenergetic health and have solicited the attending consultant's services in good faith, exerting my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.

6. I authorize the attending consultant to provide her services to me on my behalf, and hereby release her from any and all claims and potential claims arising out of my actions or failure to act upon her advice.

7. I give full faith that I have read and understand this document entirely, that I have received verbal explanation for any questions or misunderstandings of this document and/or that she has answered satisfactorily all of my questions regarding the information on this document.

8. **I certify that I am NOT pregnant, I do NOT have an organ transplanted into me and I do NOT have a pacemaker implanted in me.**

9. I am willing to declare under oath all of the above statements by request of the attending consultant.

I hereby consent to and authorize the above described evaluation and consultation:

_____ _____

Member's Signature Date

_____ _____

Parent or Guardian's Signature if Member is under age 18 Date