Health and Well Being History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Other Phone:
Cellular Phone:	Referred by:
Date:	Date of Birth:

PART 1.

* Please answer the following questions honestly and to the best of your ability.

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, and if so when?

What are your goals from somatic therapy?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

PART 2.

* Please mark the circle that best describes the frequency you experience the below conditions. **Leave blank if there is never a problem.**

1 Rarely (once a month or less)
2 Occasionally (less than once a week)
3 Frequently (more than once a week)
4 Constantly

DIGESTION

1 2 3 4 Loose stool or Diarrhea	1 2 3 4 Gas or belching	1 2 3 4 Blood in stool
1 2 3 4 Constipation	1 2 3 4 Stomach or intestinal pain	1 2 3 4 Black or dark stool
1 2 3 4 Poor digestion	1 2 3 4 Heartburn	1 2 3 4 Light colored stool
1 2 3 4 Parasites	1 2 3 4 Excessive appetite	1 2 3 4 Difficulty digesting oily food
1 2 3 4 Acid reflux	1 2 3 4 Poor appetite	yes no High cholesterol
1 2 3 4 Hiatal Hernia	1 2 3 4 Irritable bowels	yes no Gall stones
1 2 3 4 Nausea / vomiting	1 2 3 4 Hemorrohoids	

RESPIRATORY

1 2 3 4 Wet cough	1 2 3 4 Nasal problems	1 2 3 4 Other: _____
1 2 3 4 Dry cough	1 2 3 4 Poor sense of smell	yes no Pneumonia
1 2 3 4 Chest tightness	1 2 3 4 Sinus problems	yes no Asthma
1 2 3 4 Shortness of breath	1 2 3 4 Allergies	yes no Emphysema
1 2 3 4 Congestion	1 2 3 4 Hay fever	yes no Bronchitis
1 2 3 4 Wheezing	1 2 3 4 Catches colds easily	yes no Do you smoke? Number per day: ____

CARDIOVASCULAR

1 2 3 4 Hypertension	1 2 3 4 Restlessness	yes no Heart disease
1 2 3 4 Hypotension	1 2 3 4 Heart palpitation	yes no Phlebitis
1 2 3 4 Chest pain	1 2 3 4 Slow heart rate	1 2 3 4 Poor blood clotting
1 2 3 4 Dizziness	1 2 3 4 Poor circulation	yes no Heart attack How many times? ____
1 2 3 4 Easily bruised	1 2 3 4 Blood clots	yes no Stroke How many times? ____
1 2 3 4 Edema	1 2 3 4 Sweaty hands / feet	yes no Other: _____
1 2 3 4 Cold hands / feet	1 2 3 4 Anemia	

URINARY

1 2 3 4 Painful urination	1 2 3 4 Ear aches	yes no Low back pain
1 2 3 4 Incontinence	yes no Hearing impairment	yes no Knee problems
1 2 3 4 Difficulty with urination	yes no Kidney stones	yes no Other: _____
1 2 3 4 Ringing in ears	yes no Kidney infections	

NERVOUS SYSTEM

yes no Dyslexia	yes no Epilepsy	yes no Developmental or growth problems
yes no Learning disorder	yes no Head injury	yes no Nervous disorder? Type: _____
yes no Multiple Sclerosis	yes no Numbness, Where? _____	
yes no Muscular dystrophy	yes no Tingling, Where? _____	

MUSCLES / JOINTS

1 2 3 4 TMJ pain	1 2 3 4 Arm Weakness	yes no Rheumatoid Arthritis
1 2 3 4 Facial pain	1 2 3 4 Trunk Weakness	yes no Artificial joints
1 2 3 4 Loss of Balance	1 2 3 4 Difficulty walking	yes no Broken bones, fractures? _____
1 2 3 4 Poor coordination	1 2 3 4 Joint swelling	_____
1 2 3 4 Leg Weakness	yes no Osteoarthritis	yes no Pins, etc? _____

MUSCLES / JOINTS (cont)

Mark the circle of painful areas, and indicate on which side: (R) right and / or (L) left

yes no Shoulder R L	yes no Legs R L	yes no Mid back R L
yes no Arm R L	yes no Knee R L	yes no Low back R L
yes no Elbow R L	yes no Foot R L	yes no Limited movement? Where? _____
yes no Hands R L	yes no Neck R L	
yes no Hip R L	yes no Upper back R L	

OTHER

1 2 3 4 Insomnia	1 2 3 4 Fatigue	yes no Weight loss
1 2 3 4 Depression	1 2 3 4 Difficulty with speech	yes no Tuberculosis
1 2 3 4 Sleep too much, how long? _____	1 2 3 4 No thirst	yes no Thyroid problems
1 2 3 4 Shaky	1 2 3 4 Excessive thirst	yes no Fibromyalgia
1 2 3 4 Poor memory	1 2 3 4 Dry mouth	yes no Poor sense of smell
1 2 3 4 Difficulty paying attention	1 2 3 4 Pain at night	yes no Poor sense of taste
1 2 3 4 Anxiety	1 2 3 4 Headaches	yes no Cancer, Where? _____
1 2 3 4 Easily angered	1 2 3 4 Migraines	yes no Allergies? List: _____
1 2 3 4 Obsessive tendencies in work relationships	1 2 3 4 Eye pain	
1 2 3 4 Difficulty making plans or decisions	1 2 3 4 Dry eyes	yes no Hepatitis? type: ____
1 2 3 4 Dizziness	1 2 3 4 Watery eyes	yes no Infectious disease: _____
1 2 3 4 Soft or brittle nails	1 2 3 4 Other eye problems? _____	yes no Herpes
1 2 3 4 Intolerance to temperature / weather changes	yes no Dental problems	yes no Candida
1 2 3 4 Fever	yes no Poor hearing	yes no Shingles
1 2 3 4 Chills	yes no Difficulty swallowing	yes no Chemical dependency _____
1 2 3 4 Nose bleeds	yes no Diabetes	
1 2 3 4 Swollen glands	yes no Weight gain	yes no Skin condition: ____

MEN ONLY

1 2 3 4 Prostate problems	1 2 3 4 Impotence	yes no Infertility
1 2 3 4 Pain associated with genitals	1 2 3 4 Problems urinating	yes no Prostate cancer

WOMEN ONLY

1 2 3 4 Breast pain or tenderness	yes no Menopausal symptoms: _____	yes no Ovarian cysts
yes no Breast lumps	yes no Are your cycles regular? Length of cycle: _____	yes no Endometriosis
yes no Nipple discharge	yes no Painful menses with heavy or excessive flow	yes no PMS
yes no Menopause	yes no Painful intercourse	yes no Infertility

WELL BEING

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is _____:	◯ None	◯ Minimal	◯ Moderate	◯ Severe

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often?

How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain: _____

PART 3.

* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

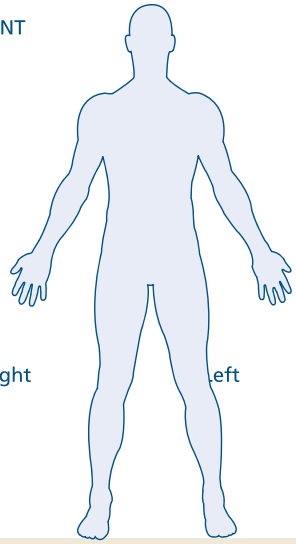
1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

① ② ③ ④ ⑤ ⑥ ● ⑧ ⑨ ⑩ example: *neck*	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

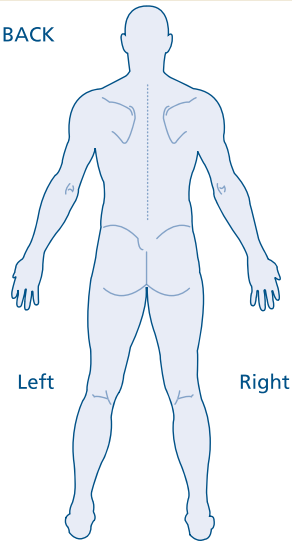
PART 4.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.

FRONT



BACK



COMMENTS:

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date:

Somatic Energy Therapy and Somatic Experiencing Informed Consent

This letter is to inform you of what I offer and do not offer in my sessions, and will help to orient you to our professional relationship. Please read it carefully before signing.

Energy Therapy

I am an Advanced Parama BodyTalk Practitioner and have taken approximately 40 BodyTalk courses (almost all that are available) and have been practicing since 2008. I have studied numerous energy healing modalities over the last decades, and am a Certified Reiki and Cranial Sacral Practitioner, Yoga Teacher and Mindfulness Life Coach.

I have studied energy therapies that use a holistic approach to healing, based on proven principles of energy medicine. They help to synchronize the body's natural functions - to achieve and maintain healing and growth on all levels: physical, emotional, mental and spiritual and many are supported by research. Energy therapy is intended to enhance relaxation, increase communication within the areas of the body, and to educate as to possible energetic or emotional blocks that may create pain and disease. They utilize the body's own innate intelligence to re-establish communication within the body, are non-invasive and safe modalities. They are not a substitute for medical treatment or medications, nor do they diagnose illness, disease or prescribe medications.

I have also traveled extensively to study with well-known Zen Buddhist and Advaita Vedanta Masters in Europe and Asia and have spent long periods of time at their Monasteries and Ashrams, and so include work on the Spirit level whenever clients are open to it, particularly as trauma can act as a portal to a depth of connection with our Spirit/Spirituality.

Somatic Experiencing®

I have received Somatic Experiencing Practitioner certification and completed my 3 year Professional Training in Fall 2020. I have completed advanced SE work on the integration of near death experiences and have been integrating this work into my practice since 2016. Please note that I do not offer psychotherapy services.

Somatic Experiencing® (SE) is a short-term naturalistic approach to the resolution and healing of trauma developed by Dr. Peter Levine and is supported by various clinical trials. The word “trauma” in this sense covers a wide range of physical and psychological symptoms that result from the effect of accumulated stress on human physiology. SE is based upon the observation that wild prey animals, though threatened routinely, are rarely traumatized. Animals in the wild utilize innate mechanisms to regulate and discharge the high levels of energy arousal associated with defensive survival behaviors. These mechanisms provide animals with a built-in “immunity” to trauma that enables them to return to normal in the aftermath of highly “charged” life-threatening experiences.

SE supports individuals in completing basic fight, flight, and freeze response patterns that remain inhibited after stressful or traumatic experiences. The completion of these response patterns brings a greater capacity for self-regulation as well as an increased sense of well-being, and integration. Even though SE primarily targets issues of trauma, it is also an effective way of supporting individuals interested in expanding their ability to authentically be in the world physically, psychologically, and spiritually. Somatic Experiencing® (SE) is not a substitute for medical treatment or medications, nor does it replace psychotherapy.

- SE employs awareness of body sensation to help people "renegotiate" and heal rather than re-live or re-enact trauma.
- SE's guidance of the bodily "felt sense," allows the highly aroused survival energies to be safely experienced and gradually discharged.
- SE may employ touch in support of the renegotiation process.
- SE "titrates" experience (breaks down into small, incremental steps), rather than evoking catharsis - which can overwhelm the regulatory mechanisms of the organism.

For further information online about Somatic Experiencing® (SE), please visit:
www.somaticexperiencing.com or www.traumahealing.org

Consent to Participate in Sessions

Please read the following statements and sign below so that we are clear about the parameters of our sessions. If you have any questions, please feel free to ask.

- I understand that Jaya Hollohan has completed various Energy Therapy certifications, her 3 year Professional SE certification training, as well as advanced SE work.
- I understand that occasionally following sessions, symptoms may feel worse until they feel better, while a potential healing reaction integrates and then subsides.
- I give Jaya Hollohan permission to facilitate the modalities of (Please initial beside whichever is applicable or both):
  Energy Therapy : _____
  Somatic Experiencing : _____
- I understand that Jaya Hollohan does not provide Psychotherapy.
- I understand that any information I provide during sessions with Jaya Hollohan is confidential. Jaya Hollohan will not disclose information without my consent except if:
  - I demonstrate credible threat to harm myself or others.
  - Any information that indicates neglect or abuse of a minor child or dependent adult or elder abuse.

I give Jaya Hollohan permission to use touch during sessions, if they are in person. I understand that touch is not intended to physically manipulate tissue, is non-sexual, and is only used when necessary for the support of awareness. I also understand that it is my responsibility to inform Jaya if I am at any time uncomfortable with touch.

Please sign here if you **do not** want to incorporate touch into your sessions:

_____

Client Printed Name : _____
Client Signature : _____
Date : _____

Thank you for your attention and I look forward to working with you on your healing journey!

Finding Your Ace Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you eever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you oten or very often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you often or very often feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.