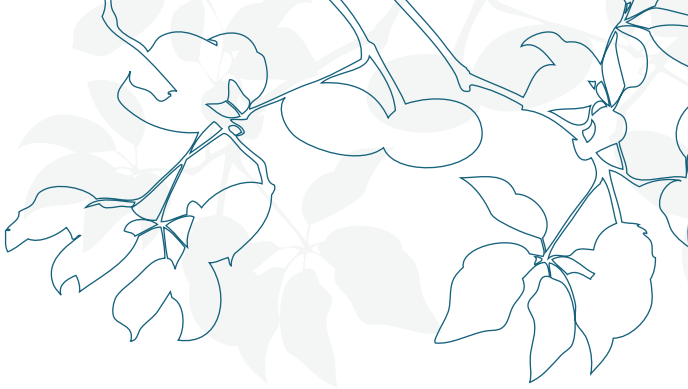
BODY BALANCE Hellerwork and Structural Medicine
promoting body awareness and balance
Julie Jeffery Peale, CHP, SMS



Client and Therapist Agreement

The mission of Julie Jeffery Peale and Body Balance is to create a safe environment for healing. My intention is to be a co-creator with you in your process toward health through hands on applications, movement education, and open dialogue.

Julie Jeffery Peale, CHP, recognizes that every individual goes through their healing process at a different pace and in a different way. I promise to respect your process and be fully present during your treatment.

What should you wear to your session? Please be advised that the session will be conducted with you in your undergarments. Because of the structural changes throughout the session, it works best if I can see the body as a whole.

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As a client, I am aware of the mission statement. I recognize that healing is a process and not an event. As I understand that my therapist will facilitate this process, I do not expect her to "fix" me. Furthermore, I understand that the primary goal of Hellerwork and Structural Medicine is to improve alignment and or the organization of the body's structure. Relief of physical or emotional symptoms is coincident with the alignment and or organization of the total human being.

I am here as a client because I am ready to commit to my healing. I pledge to be present during therapy time, to ask questions when I do not understand information, and to share important information about my health with my therapist. I understand that Julie Jeffery Peale is a Certified Hellerwork Practitioner and Structural Medicine Specialist and that she does not treat, prescribe for, or diagnose any illness, disease or condition.

I understand that photographs may be taken as a visual aid for both myself and for my therapist. These photos will be kept in my confidential medical record.

I agree to pay in full for any appointment that I miss or do not cancel at least 24 hours in advance.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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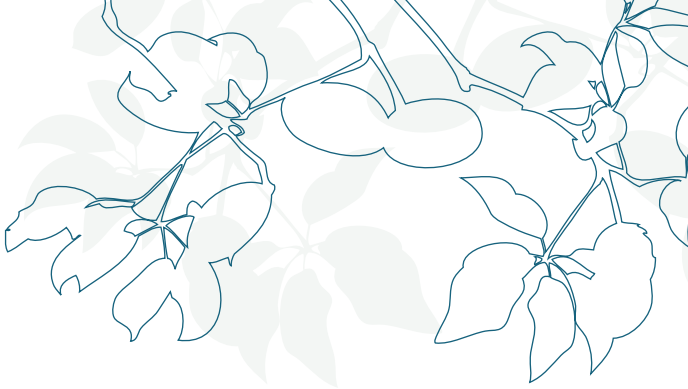


Personal Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Profession: _____ E-mail: _____

Date of Birth: _____

Health Information

How did you hear about Body Balance & Julie Jeffery Peale? _____
What is your major complaint or condition that you want to improve? _____

_____

_____

When did you first notice the complaint? _____

What brought it on? _____

What activities aggravate the condition? _____
improve the condition? _____

Is the condition progressively getting worse? yes / no
Please explain: _____

_____

Does the condition interfere with work or daily routine? yes / no Sleep? yes / no
Please explain: _____

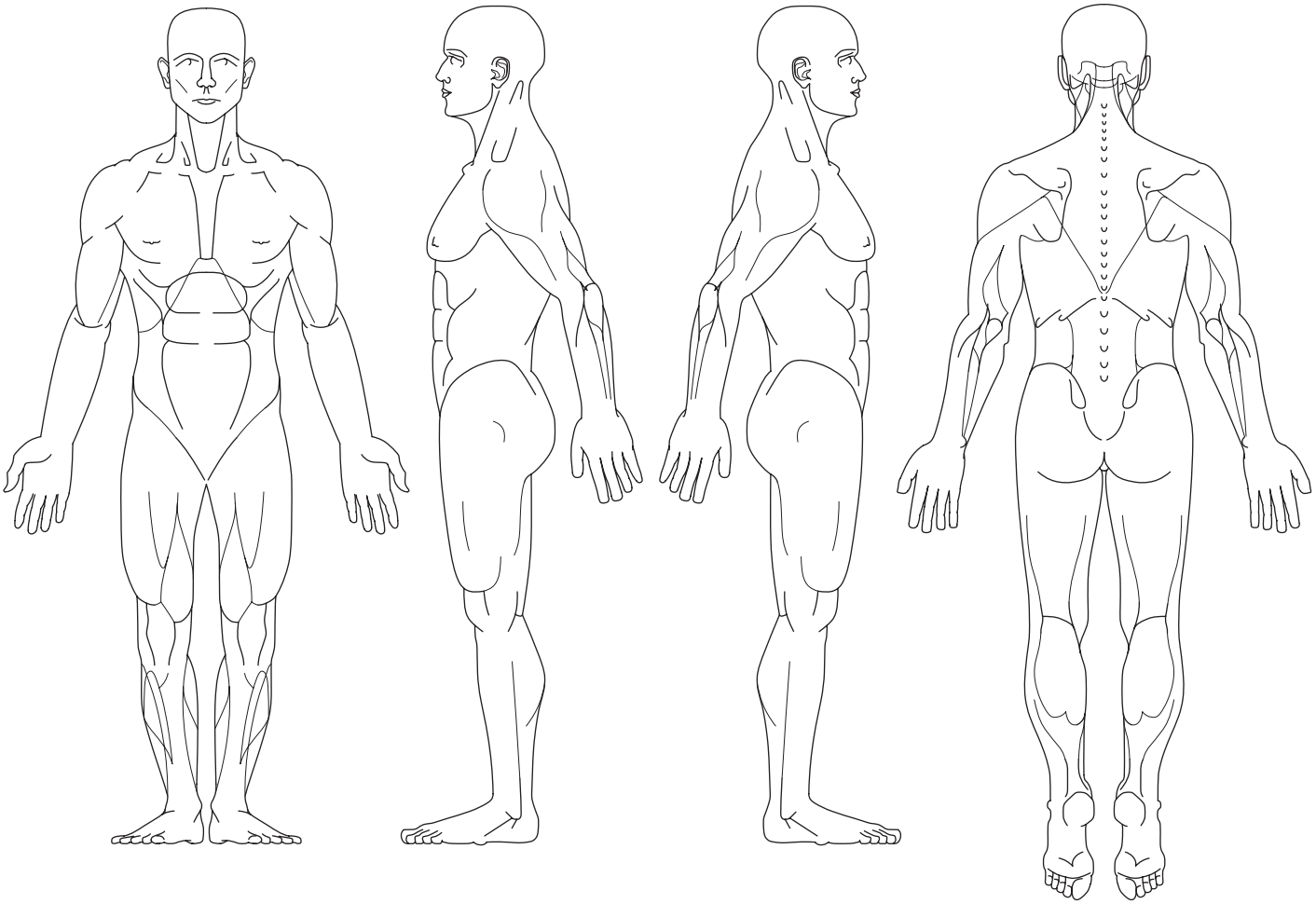
_____

Do you currently experience any of the following? Please explain.

1. Poor Posture or alignment: _____
2. Restriction in movement: _____
3. Tension: _____
4. Aches and Pains: _____
5. Other Problems: _____

Date: _____

Shade in the area on the figure of current pain & symptoms.



Notes:

Name: _____ Date: _____

Have you ever had:

Serious Accident / Injury (including car accidents):

date	explanation

Surgery (including cosmetic procedures):

Broken Bones:

Have you ever had bodywork/ massage? If so, what type and was it effective? _____

_____

What are you doing for yourself on a regular basis? (ie, exercise, bodywork, massage, chiropractic) _____

_____

List medications you took today, including pain relievers and herbal remedies (use the back of this page if more room is needed): _____

_____

_____

_____

_____

What specific results do you want to experience from Hellerwork in your body and in your life? _____

_____

_____

Please list any additional comments regarding your health and well-being that have not already been covered:

_____

_____

_____

_____

_____

_____

Name: _____ Date: _____

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Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-skeletal
- _ _ Headaches
- _ _ Joint Stiffness / Swelling
- _ _ Back, hip pain
- _ _ Shoulder, neck, arm, hand pain
- _ _ Leg, foot pain
- _ _ Chest, ribs, abdominal pain
- _ _ Problems walking
- _ _ Jaw pain
- _ _ Tendonitis
- _ _ Bursitis
- _ _ Arthritis (Osteo- or Rheumatoid)
- _ _ Osteoporosis
- _ _ Scoliosis
- _ _ Bone or joint disease
- _ _ Disc problems
- _ _ Other : _____

Circulatory and Respiratory
- _ _ Shortness of breath
- _ _ Swollen Ankles
- _ _ Varicose Veins
- _ _ Blood clots
- _ _ Stroke
- _ _ Heart condition
- _ _ Allergies
- _ _ Sinus problems
- _ _ Asthma
- _ _ High blood pressure
- _ _ Low blood pressure
- _ _ Lymphedema
- _ _ Other : _____

Skin
- _ _ Rashes
- _ _ Skin Sensitivies
- _ _ Athlete's Foot
- _ _ Warts
- _ _ Other: _____

Digestive / Elimination
- _ _ Nervous stomach
- _ _ Constipation
- _ _ Diarrhea
- _ _ Irritable Bowel Syndrome
- _ _ Abdominal Pain
- _ _ Other: _____

Nervous System
- _ _ Numbness / tingling
- _ _ Twitching of face
- _ _ Fatigue
- _ _ Chronic pain
- _ _ Sleep disorders
- _ _ Ulcers
- _ _ Paralysis
- _ _ Herpes / Shingles
- _ _ Epilepsy
- _ _ Spinal cord injury
- _ _ Sciatica
- _ _ Head Injury / Concussion
- _ _ Other: _____

Reproductive System
- _ _ Pregnancy
  _ past _ current
- _ _ PMS
- _ _ Menopause
- _ _ Pelvic Inflammatory Disease
- _ _ Endometriosis
- _ _ Hysterectomy
- _ _ Fertility concerns
- _ _ Ovarian Cysts

Endocrine
- _ _ Diabetes (Type I or Type II)

Other
- _ _ Eating Disorder
- _ _ Forgetfulness
- _ _ Confusion
- _ _ Depression
- _ _ Difficulty concentrating
- _ _ Drug Use: _____
- _ _ Alcohol Use: _____
- _ _ Nicotine Use: _____
- _ _ Caffeine Use: _____
- _ _ Hearing Impaired
- _ _ Visually Impaired
- _ _ Bladder infection
- _ _ Fibromyalgia
- _ _ Cancer
- _ _ Sexual Abuse / Assult
- _ _ Other: _____

Additional Comments: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any change in my status.

Client's Signature: _____ Date: _____