



770 S. Broadway  
Denver CO 80209  
(303) 884-9642

Breakthrough Body Healing, LLC is committed to excellence in serving the health needs of the community. We are dedicated to giving each client a personal service that they can rely & trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask, we will be happy to assist you.

### Client Information

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Current address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: H \_\_\_\_\_ W \_\_\_\_\_ C \_\_\_\_\_

Email : \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ D.O.B. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Doctor \_\_\_\_\_

Who can I thank for this referral? \_\_\_\_\_

## MEDICAL HISTORY

Do you smoke?

Yes  No

*Years smoked:* \_\_\_\_\_

*Packs per day:* \_\_\_\_\_

Use artificial sweeteners?

Yes  No

Drink diet soft drinks?

Yes  No

*Drinks per day:* \_\_\_\_\_

Usually sleep through the night?

Yes  No

Sleep with a pillow between your knees?

Yes  No

Take any statin drugs (cholesterol lowering)?

Yes  No

Cradle your phone against your shoulder?

Yes  No

Carry your wallet in your back pocket?

Yes  No

Carry your purse over your shoulder?

Yes  No

How old is your mattress?

\_\_\_\_\_ years

Current Medications:

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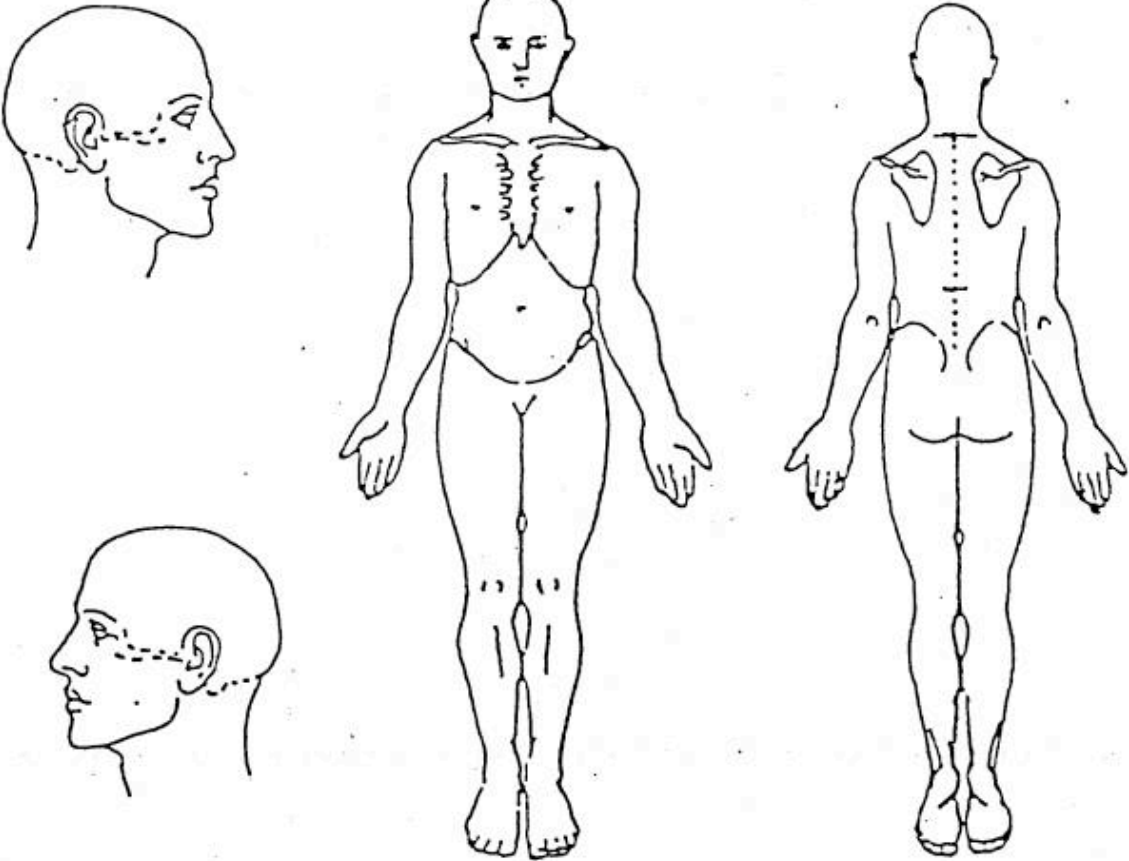
Allergies to: drugs, food, or other items (including latex):

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Current symptoms:



Please indicate on the diagram the location of your current symptoms:



Do you exercise?

Yes  No

If yes, what type of exercise? \_\_\_\_\_

How often? \_\_\_\_\_

Pain Level: (0 being none and 10 being the worst)

1  2  3  4  5  6  7  8  9  10

Stress Level: (0 being none and 10 being the worst)

1  2  3  4  5  6  7  8  9  10

Are the following foods prevalent (3x/week) in your diet?

Tomatoes  Potatoes  Peppers  Eggplant  Tobacco

Please List All Operations/Surgeries:

Operation Performed (even as a child)

_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____

Please check if YOU have had any of the following conditions:

- |  |  |
|--|--|
| <input type="radio"/> Insomnia                                 | <input type="radio"/> PTSD                     |
| <input type="radio"/> High Blood Pressure                      | <input type="radio"/> High Cholesterol         |
| <input type="radio"/> Mental Illness/Depression                | <input type="radio"/> Candida (yeast allergy)  |
| <input type="radio"/> Diabetes (type I or II)                  | <input type="radio"/> Heart Attack/Disease     |
| <input type="radio"/> Arthritis                                | <input type="radio"/> Celiac Disease           |
| <input type="radio"/> Thyroid Dysfunction                      | <input type="radio"/> Asthma                   |
| <input type="radio"/> Cancer                                   | <input type="radio"/> Dizziness                |
| <input type="radio"/> Alcoholism                               | <input type="radio"/> Anxiety                  |
| <input type="radio"/> Substance abuse                          | <input type="radio"/> Irritable bowel syndrome |
| <input type="radio"/> Fibromyalgia                             | <input type="radio"/> Chronic fatigue syndrome |
| <input type="radio"/> Restless leg syndrome                    | <input type="radio"/> Diarrhea                 |
| <input type="radio"/> Carbon monoxide poisoning                | <input type="radio"/> Difficulty swallowing    |
| <input type="radio"/> Multiple chemical sensitivity            | <input type="radio"/> Difficulty speaking      |
| <input type="radio"/> Attention Deficit Hyperactivity Disorder | <input type="radio"/> Intrusive thoughts       |
| <input type="radio"/> Phobias _____                            | <input type="radio"/> Stroke                   |

Please check if YOU have had any of the following conditions:

- |   |  |
|---|--|
| <input type="radio"/> Eating Disorder       | <input type="radio"/> Brain Injury               |
| <input type="radio"/> Migraine Headaches    | <input type="radio"/> Blood Clots                |
| <input type="radio"/> Shortness of breath   | <input type="radio"/> Heart Palpitations         |
| <input type="radio"/> Reflux                | <input type="radio"/> Lyme disease               |
| <input type="radio"/> Concussion            | <input type="radio"/> Stuttering                 |
| <input type="radio"/> Difficulty swallowing | <input type="radio"/> Attention Deficit Disorder |

Other conditions not listed: \_\_\_\_\_  
\_\_\_\_\_

Anything else you would like me to know about your history:  
\_\_\_\_\_  
\_\_\_\_\_

Client Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client Signature: \_\_\_\_\_

\_\_\_\_\_  
Teena Evert MA, CSIP

# Teena Evert, MA, CSIP, RYT

## Structural Integration Practitioner

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770 S. Broadway  
Denver, CO 80209  
303-884-9642  
303-484-1500 (fax)  
teena@breakthroughbodyhealing.com  
www.breakthroughbodyhealing.com

### **Disclosure Statement**

#### **Education**

Master of Arts in Clinical Psychology, specialty Prenatal & Perinatal Psychology  
Santa Barbara Graduate Institute, Santa Barbara CA  
Bachelor of Arts in Biology  
Wittenberg University; Springfield OH

#### **Professional Licenses, Certifications, Registrations, and Trainings**

Registered Psychotherapist in the state of Colorado #11034  
Registered Massage Therapist in the state of Colorado #2637  
NCTMB, Nationally Certified Therapeutic Massage & Bodywork #573076  
RYT500, Registered Yoga Teacher through Yoga Alliance  
Primal Reflex Release, August 2009; Canton OH  
Sensory Motor Manual Therapy, June 2009; Boulder CO  
Myoskeletal Alignment Training, May 2009; Oklahoma City OK  
Sensorimotor Psychotherapy Training, August 2008; Boulder, CO  
Self-Regulation Psychotherapy Training, November 2007; Vancouver BC  
Structural Integration Practitioner, February 2002; Boulder CO

#### **Professional Memberships and Affiliations**

American Psychological Association  
American Mental Health Counselors Association, Alexandria VA  
Association of Massage and Bodywork Professionals, Golden CO  
Colorado Association for Infant Mental Health, Denver CO  
Canadian Foundation for Trauma Research & Education, Vancouver BC  
Iyengar Yoga National Association of the United States, Seattle WA  
The Association for Prenatal & Perinatal Psychology & Health, Forestville, CA  
The International Association for Yoga Therapy, Prescott AZ  
The International Association for Structural Integrators, Missoula MT  
The Guild for Structural Integration, Boulder CO  
United States Association for Body Psychotherapy, Silver Springs MD

#### **Treatment: Methods, Duration, and Cost**

Treatment requires a commitment of time, emotional & physical energy and money, and it is most likely to be helpful to you when you are ready to investment yourself in these ways. Structural Integration and Alignment-based yoga therapeutics are

processes of re-educating and releasing deeply set patterns of negative postural holding in the connective tissue , and at times you may temporarily feel worse rather than better. The process may also assist you to make meaningful changes in your body-mind complex and a deeper understanding of yourself and others.

At the end of our initial consultation, I will discuss my recommendations for treatment with you, and together we will decide how to proceed. I expect that questions about the methods, effectiveness, and duration of treatment will be raised by both of us at regular intervals during the course of treatment in order to evaluate progress, make adjustments, and to decide when to end your therapy. You are encouraged to discuss these topics and are reminded that you may end treatment at any time. You may also seek a second opinion if you wish to do so.

My standard fee for Structural Integration is \$125 for a 90-minute session. My standard fee for Alignment-based yoga therapeutics is \$100 for a 60 minute session. Fees are payable at the beginning of each session. You will be charged for all missed or canceled sessions unless 24 hours advance notice is given. In case of accident or illness which onset less than 24 hours before the appointment, call to cancel your session as soon as possible. In general, I do not charge for phone consultation, unless there are unusual circumstances. Should phone charges occur, I will, discuss this with you.

### **Electronic Communication**

My email address is: teena@breakthroughbodyhealing.com. Feel free to email me regarding administrative concerns, such as cancellations and scheduling changes. Please do not discuss confidential information in email, as email is not a secure method for private communication. Please do not use email as a method of contacting me in the event of an emergency.

### **Emergency Contact Options**

You can reach me by my cell phone at 303-884-9642. I will return all voice mail messages as soon as possible. If you are in emergent need and unable to reach me, call 911, or go to the nearest hospital emergency room.

### **Termination of services**

Termination of therapeutic services may occur at any time and may be initiated by either you or your therapist. Please contact me if you decide to discontinue your treatment so that we can schedule for a final session. Termination itself can be a very constructive process, and I encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are needed, I can provide those when we meet.

### **Consent to Treatment**

I consent to participation in therapeutic services with Teena Evert, MA, CSIP, and I agree to the policies of her practice as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have been given a copy of this document for my own records.

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

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Client Signature

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Date

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Teena Evert, MA CSIP, RYT

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Date

**Teena Evert, MA, CSIP, RYT  
Structural Integration Practitioner**

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**Credit Card Guaranty of Payment**

I authorize Teena Evert, MA, CSIP to charge my credit card to pay balances over \$150 and/or over 60 days overdue. Alternatively and if desired, I authorize a one- time payment of \$\_\_\_\_\_ to pay the remaining overdue balance on my account.

The name and billing address for this credit card is:

Client Name \_\_\_\_\_

Cardholder name \_\_\_\_\_

Cardholder Billing Address \_\_\_\_\_

Card Type                      Visa    MasterCard

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

I understand that these balances may include charges for missed visits ("no-shows") and for late cancellations.

I understand that I will be held responsible for any charges or fees if authorization is declined.

I will provide notice immediately if I close this account.

I understand that Teena Evert is relying on this information in continuing to provide services to me.

\_\_\_\_\_

Client Printed Name

\_\_\_\_\_

Date

\_\_\_\_\_

Client Signature

\_\_\_\_\_