



REGENERATIO  
YOUR BODY HEALED

CLIENT INTAKE FORM

## Welcome to **REGENERATIO!**

As a natural wellness practitioner, it is my purpose to help you achieve your desired wellness goals using the holistic approach to healing. My core principle is to teach you methods of healing, to allow you to take back control of your health and well-being. What I offer includes natural methods of healing and therefore will recommend foods and herbs that will help bring your body into balance. Treatments are tailored to support your unique needs and will encourage your body's innate ability to heal.

Therapies used in my practice include Bioenergetic Scanning, Nutrition Therapy and Coaching, Traditional and Neo-biofeedback, Auricular Therapy, Sound Therapy, Homeopathy, Iridology, Medical Astrology, Energy Work, Access Bars, Reflexology, Essential Oils, and more...

## DISCLOSURE AND PRACTICE POLICIES STATEMENT

### Required for New Patient Consultation

1. The completed new client questionnaire. Please allow 30-45 minutes to complete most of this questionnaire.
2. Please send prior to your visit any **labs, blood tests, or other pertinent medical information** you think may be helpful.

*Under current Colorado law Nutrition Therapy and Bioenergetic Medicine is not deemed the practice of medicine. The services provided by Melissa Simmons are at all times restricted to consultation on the subject of lifestyle and nutritional matters.*



**Point Scale:**

- 0:** Never or almost never have the symptom.
- 1:** Occasionally have it; effect is not severe.
- 2:** Occasionally have it; effect is severe.
- 3:** Frequently have it; effect is not severe.
- 4:** Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

**SYMPTOM QUESTIONNAIRE**

**EYES**

Watery or itchy eyes  
Swollen, reddened, or sticky eyelids  
Bags or dark circles under the eyes  
Blurred or tunnel vision  
Slurred speech

**TOTAL**

**MOUTH/THROAT**

Chronic coughing  
Gagging, frequent need to clear throat  
Sore throat, hoarseness, loss of voice  
Swollen or discolored tongue, gums, lips  
Canker sores

**TOTAL**

**NOSE**

Stuffy nose  
Sinus problems  
Hay fever  
Sneezing attacks  
Excessive mucus formation

**TOTAL**

**WEIGHT**

Binge eating/drinking  
Craving certain foods  
Excessive weight  
Compulsive eating  
Water retention  
Underweight

**TOTAL**

**SKIN**

Acne  
Hives, rashes, or dry skin  
Hair Loss  
Flushing or hot flashes  
Excessive sweating

**TOTAL**

**OTHER**

Frequent illness  
Frequent or urgent urination  
Genital itch or discharge  
Other

**TOTAL**



## SYMPTOM QUESTIONNAIRE

### DIGESTIVE TRACT

Nausea or vomiting  
Diarrhea  
Constipation  
Bloating feeling  
Belching or passing gas  
Heartburn

### TOTAL

### EARS

Itchy ears  
Earaches, ear infections  
Drainage from ear  
Ringing in ears, hearing loss

### TOTAL

### EMOTIONS

Mood swings  
Anxiety, fear, or nervousness  
Anger, irritability, or aggressiveness

### TOTAL

### ENERGY/ACTIVITY

Fatigue, sluggishness  
Apathy, lethargy  
Hyperactivity  
Restlessness

### TOTAL

### HEAD

Headaches  
Faintness  
Dizziness  
Insomnia

### TOTAL

### HEART

Irregular or skipped heartbeat  
Rapid or pounding heartbeat  
Chest Pain

### TOTAL

### JOINTS/MUSCLES

Pain or aches in joints  
Arthritis  
Stiffness or limitation in movement  
Pain or aches in muscles  
Feeling of weakness or tiredness

### TOTAL

### LUNGS

Chest congestion  
Asthma, bronchitis  
Shortness of breath

### TOTAL.

### GRAND TOTAL

### MIND

Poor memory  
Confusion, poor comprehension  
Poor concentration  
Difficulty in making decisions  
Stuttering or stammering  
Learning disabilities

### TOTAL





I, \_\_\_\_\_, understand that methods of treatment used in this practice may include, but is not limited to: Nutrition Counseling, Traditional and Neo-Biofeedback, Lifestyle Coaching and Auriculotherapy.

Initials\_\_\_\_\_

I understand that Melissa Simmons is not a medical doctor. If a medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor. The advice or treatment provided by Melissa Simmons should not in any way be confused or replace the advice of a licensed medical doctor.

Initials\_\_\_\_\_

I understand that any medical records and lab reports I share with REGENERATIO will be kept confidential. If at any time it becomes necessary to share my health information, it will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

Initials\_\_\_\_\_

I understand that a health record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Initials\_\_\_\_\_

I understand that the form of care provided at this practice is based on holistic medicine and other supportive principles and practices. I recognize that even the gentlest therapies may cause complications in certain physiological conditions such as pregnancy, lactation, those on multiple medications, and/or medical implants such as, but not limited to a pacemaker. As a client, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment.

Initials\_\_\_\_\_

I understand that health risks associated with this form of treatment include but are not limited to aggravation of pre-existing symptoms and/or allergic reactions to supplements or herbs.

Initials\_\_\_\_\_

I therefore confirm that I will inform, and will continue to inform, Melissa Simmons fully of my medical history, family history, medications, and/or supplements I am currently taking (prescription and over the counter) or was previously taking. If female, I will advise Melissa Simmons immediately if I am pregnant, suspect I am pregnant, am trying to become pregnant, or breastfeeding, and will continue to do so.

Initials\_\_\_\_\_



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## INFORMED CONSENT FOR TREATMENT

I understand that Melissa Simmons will answer any questions that I have to the best of her ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect Melissa Simmons to be able to anticipate and explain all risks and complications.

Initials\_\_\_\_\_

I understand that no practitioner under REGENERATIO is suggesting or advising me to refrain from seeking or following the directions of another licensed healthcare provider. I am at liberty to seek or continue medical care from a licensed healthcare provider of my choosing. Any treatment or advice provided to me as a client is not mutually exclusive from any treatment or advice that I may currently be receiving (now or in the future), from a licensed healthcare provider.

Initials\_\_\_\_\_



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**MEDICAL INFORMATION RELEASE FORM**  
(HIPPA RELEASE FORM)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**RELEASE OF INFORMATION**

I authorize the release of information including the diagnosis, records; examination rendered to me, and claims information. This information may be released to:

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Other: \_\_\_\_\_

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**MESSAGES**

Please call (circle)

My home: \_\_\_\_\_ My work: \_\_\_\_\_ My cell number: \_\_\_\_\_

Initials \_\_\_\_\_

If unable to reach me: (circle)

You may leave a detailed message

Please leave a message asking me to return your call

Other \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_