

Health Declaration

Please fill out the following Health History Intake form prior to your appointment. All information is kept confidential in compliance with HIPPA Regulation. Thank you.

First & Last Name

Emergency Contact

Date of Birth

Email

Have you been hospitalized in the last 12 months?

- No
 Yes

Are you currently being treated for any medical Condition or illness?

- No
 Yes

Check All That Apply:

- Abdominal Pain
 Addictions
 Allergies
 Arthritis
 Back/Neck Problems
 Cancer
 Chest Pain
 Depression
 High/Low Blood Pressure
 Diabetes
 Dizziness
 Eye Problems
 Headaches/Migraines
 Heart Disease/Palpitations
 Infectious Disease
 Joint Replacement
 PaceMaker/Defibrillator Implant
 Pain (please specify) _____
 Behavioral/Psychological Disorder
 Seizures
 Shortness of Breath
 Thyroid Issues
 Stroke

If you answered yes to any question, please explain:

-
- I declare that the information I've provided is accurate and complete

Signature

Date

Consent Form for Coaching & Healing Session

I hereby agree and consent to the services of Transformational Coaching and BioField Energy Healing performed by Deborah Mammina, Certified HeartMath Clinical Practitioner and Certified Vibrational Sound Healing Practitioner. I understand that I am not receiving a Western medical diagnosis or treatment, therefore, any health concerns should be consulted and addressed with my regular medical physician.

I understand that BioField Energy Healing Sessions are to be performed while lying fully clothed on a treatment table with hands on, non-invasive sound frequency tuning forks used a few inches away from the body. Sound healing instruments, which consist of Tibetan and Crystal Sound Bowls, will only be used if requested and agreed upon in advance. I understand that this treatment is safe and I agree and declare that I do not have a PaceMaker Implant or Defibrillator Implant, and that I am of sound mind.

I understand that my session is held in complete privacy and confidentiality, no photographs will be taken or recordings of any kind. I also understand that my private medical and personal information will not be shared with anyone outside of the treatment room, all in regulation with HIPPA Standards. If I am a minor, my parent/guardian is welcome to join in the treatment room for a session.

Signature

Date

If Minor - Signature of Parent/Guardian

Date