Dr. Rachel Hamel
California Cranial Institite

Name _____**Date**_____

PLEASE PRINT and **(CIRCLE)** any appropriate responses.

Please describe your symptoms in detail (use other side if necessary):

_____
_____
_____
_____
_____
_____

Please list anything that you **believe** you are allergic to or sensitive to:

_____
_____

What allergies or sensitivities have been **confirmed** by any type of testing?

_____
_____

How long have you had your symptoms? _____
Are your symptoms: **mild** **moderate** **severe**
Each year, are your symptoms getting : **better** **worse** **no change**

What doctor recommended treatment(s) have you had in the past?

_____
_____
_____

Were they effective? **No** **Yes..which one(s)?** _____
_____

Please list **all** over the counter and prescription medications that you are taking and what they are for: _____
_____
_____

What nutritional supplements are you taking? _____
_____

Have you ever had a life-threatening allergic reaction? **No Yes…. to what?** _____

Do you have: **Celiac Disease Liver problems Weak immune System Lyme Disease Adrenal Exhaustion Candida N/A**

Do you have recurring: **Yeast infections athletes foot nail fungus N/A**

Do you have chronic: **fatigue memory problems depression headaches N/A**

Please rate your overall energy level: **poor fair good excellent**

Please rate your overall physical health: **poor fair good excellent**

Please rate your current stress level: **normal high intolerable**

PLEASE ANSWER ALL OF THE QUESTIONS BELOW.

Do you have: **asthma sneezing sinusitis watery-itchy-swollen eyes N/A**

Do you get bacterial infections in your: **sinuses lungs ears N/A**

Do you frequently get colds **Yes No**

What animals do you have _____

Do fragrances, chemical odors, or second-hand smoke irritate you sinuses or lungs? **Yes No**

Do you inhale chemical odors or other fumes on a regular basis? **Y N**

Do you or your spouse use a down/feather pillow or comforter? **Y N**

Has there been any new paitin, carpeting, etc. at your home or office during the past 6 months? **Y N**

Are your symptoms worse when you clean the house or garage? **Y N**

Do your symptoms wake you up at night? **Y N**

Are your symptoms worse when you wake up in the morning? **Y N**

Are your symptoms worse in the: **spring summer fall winter N/A**

Are your symptoms worse when you are: **indoors outdoors N/A**

Are you symptoms worse at: **work home N/A**

Do you have: **indigestion bloating diarrhea constipation N/A**

Do you get: **skin rashes itching hives eczema headaches N/A**

After eating, do you ever feel: **stimulated hyperactive fatigued N/A**

Do you take antacids or acid blocking medication **Yes No**

Please list any food or beverages that seem to cause **any** unpleasant symptoms: _____
_____
_____

What **specific** food items do you frequently eat for breakfast, lunch dinner or snacking?
_____
_____

What food or beverages do you **crave?** _____
_____

Which of these do you drink on a regular basis? **Coffee tea milk fruit juice pop diet pop beer wine soy milk rice milk other** _____

Do you have any root canals? **Yes No** If so, how many? _____
Are you wearing a pacemaker? **Yes No**

Informed Consent Agreement (CBT)

I understand that I should not discontinue any health care provided by other health care providers, and that I should fully inform other health care providers about any changes in my symptoms or conditions that result from the application of CBT procedures. I understand that I may discontinue my CBT treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

I understand that Dr. Hamel is a chiropractic physician, and no a medical doctor or a doctor of osteopathy, and she does not practice medicine. I understand that CBT techniques and procedures were developed by Dr. Smith DC, and that they are an experimental, alternative form of healthcare which is not yet proven by medical science, not yet subjected to chiropractic peer review nor taught in chiropractic colleges, and are not covered by any health insurance, Medicare or Medicaid.

I have read the above statements, and I have been provided the opportunity to as any questions regarding CBT procedures. I have also been informed that I am to notify Dr. Hamel if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

I have executed the foregoing this ____ day of _____

_____ _____

Signature Printed Name

_____ _____

If Minor, signature of parent or guardian Guardian's printed name

_____ _____

Witness signature Witness Printed Name

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