Khalsa Health Centers

Taos Khalsa
HEALTH CENTER

Northstar Plaza
#65 Hwy 522 Suite B2 El Prado, NM 87529
PO Box 609, Arroyo Seco, NM 87514
575-751-1335

Khalsa
HEALTH CENTER

Serena Plaza
2074 Galisteo Street, B-4
Santa Fe, NM 87505
505-986-8300

Patient's Name_____ Birthday_____ Age _____ Wt_____

Address _____ City_____ State_____Zip _____ Ht_____

Telephone _____Business/Work _____Cell_____

Occupation_____e-mail_____

Consent of treatment: I understand and agree that the staff at Taos Khalsa Health Center and Khalsa Health Center has a right to refuse to accept me as a patient at any time before or after treatment begins. The taking of my history and conducting physical and alternative health care examination are not considered treatment (all findings must be verified by a licensed physician), but are a part of the process of information gathering so that staff determines whether to accept me as a patient.

PATIENT'S SIGNATURE _____ Date _____

Witness Signature _____ Date_____

Patient Information (please print):

Who **Referred You?** _____

Doctor's Name _____

Doctor's Address _____

Phone # _____

Employer: _____ Address: _____

Insurance information:

Soc. Sec. _____

Are you currently not working? _____ How long have you not worked? _____

Are you involved in any law suits related to your pain? _____Check below if appropriate:

___ I have no lawsuits pending ___ I am the process of suing the state or insurance company

Married___ Single___ Widowed___ Divorced___ Children _____

Spouse's Name _____

Contact in case emergency name_____Phone_____

Name of patient if patient is a minor _____

State Information_____ Address_____

Lawyer_____ Address_____

Lawyer Phone # _____ _____

Insurance Company's Name: _____

Address: _____ Phone _____

_____ Policy # _____

_____ Case/ Claim # _____

_____ Agent _____

Date of Accident _____ Agent Phone # _____

Patient Information Continued:

Have you ever had manual therapy, massage therapy, or alternative health care? _____

List therapies: _____

_____

Your Present Symptoms & Complaints:

Please list physical symptoms, and complaints:

_____

_____

What is your present mental and emotional state from your trauma?

_____

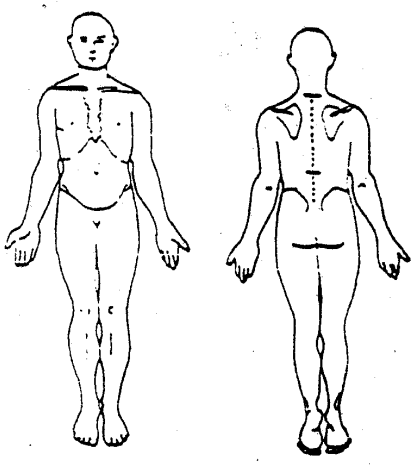
How do you believe your problem or pain began?

_____

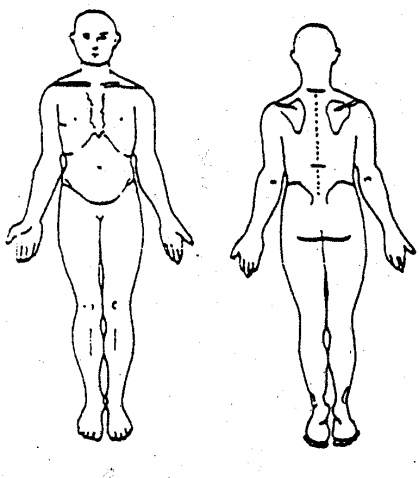
_____

Do you have an official diagnosis by a licensed physician?

Pain Diagram: Please shade in all areas of pain. Indicate the level of pain on a scale of 0 (none) to 10 (excruciating)



Other Symptoms: Please Shade all areas of severity or "funny feelings" (tingling, burning, pins & needles)



Please indicate what makes your pain worse:

Lying down____ sitting ____ standing _____ walking _____ driving ____ running ____ working _____
Too much activity ____ Too little activity _____ bending _____ reaching ___ lifting _____
Squatting ____ kneeling ____

SYMPTOMS CHECKLIST:	Never	Occasional	Often	Constant
Dizziness, Lightheadedness				
Nausea				
Ringing ears, stuffy ears, painful ears				
Vision Problems				
Decrease concentration/attention				
Short-term memory loss				
Allergies, sinus problems				
Cold hands or feet				
Low, Middle or Upper back pain (circle area)				
Balance or co-ordination problems				
Bowel or bladder problems				
Sexual function problems				
Chest pain				
Unusual bleeding or discharge				
Thickening in your breast or elsewhere				
Indigestion or difficulty in swallowing				
Change in Warts or moles or sore that does not heal				
A nagging cough or hoarseness				
Headaches/Migraines				
Have you lost consciousness				
Night sweats				
Pain in neck, jaw or face				
Faints easily				
Take birth control pills				
Pain wakes you from sleep				
Low Energy or Exhausted				
Sleep Problems				
History of stroke in family yes_____ no___				
Ever had cancer? yes____ no____				

History of Treatment:

Please list methods you have used to decrease your pain, and indicate which treatments have been effective:

_____

_____

What are your goals from receiving manual therapy?

_____

_____

Medical History:

Please indicate your present medical condition.

_____

_____

Indicate your past history of health: Stroke, heart attack, cancer, diabetes, other illnesses, broken bones, injuries etc. …. _____

_____

List operations you have undergone and dates:

_____

_____

List all traumas (including emotional) and when they occurred:

_____

_____

List all medication (including vitamins, herbs or over-the-counter drugs) you are presently taking.

TAOS KHALSA HEALTH and KHALSA HEALTH CENTER POLICIES!

1. I will not use mind altering drugs, alcohol, smoke or coffee before session.
2. I have the right to stop the session if I feel uncomfortable at any time during session!
3. I understand that I am responsible for my well being and healing process. The therapist cannot fix me or cure me!
4. I understand that my therapist is committed to assisting me in the healing process in as short a time as possible!
5. I understand that there may be reactions from the treatment, anticipated or unanticipated, or a healing crisis. You are responsible for discussing any symptoms of concern with the therapist!
6. I will agree to lifestyle changes which are very important during the healing process to prevent inflammation such as: eating no sugar, staying away from processed foods, eating no foods from the nightshade family, eating no wheat or lactose (if intolerant), drinking plenty of water (2 quarts a day); refraining from stimulants like coffee, tea, chocolate etc., and getting proper rest and doing moderate activities during the healing process.
7. I understand that if I need to cancel an appointment, I will do so with 24 hours to 3 days prior to the appointment. I understand there will be a $45 charge if I cancel less than 24 hours before appointment. PLEASE BE ON TIME - try to arrive 10-15 MINUTES BEFORE SESSION!
8. I understand payment is required at the time service is rendered. I understand that even though I may have insurance, I am still responsible for 100% of fees, regardless of whether or not my insurance company pays only a percentage of reimbursement.
9. I understand that if I am a no-show, I will be charged the full amount agreed upon, which will be for 1 hour.
10. I will be considerate and have good hygiene and refrain from wearing perfumes or colognes!
11. I agree that Harbhajan charges by the hour and by the minute thereafter.

12. I understand that Harbhajan charges using a sliding scale for prepaid contracts:

Name: _____ Agrees to rate of $ _____ / hour. Please initial _____
The first session is usually 1 to 2 hours.

13. I AGREE TO ALL POLICIES ABOVE! Please sign _____

PREPAID SESSION CONTRACTS FOR BODYWORK, MANUAL THERAPY AND CONSULTATION SESSIONS ARE NON -REFUNDABLE, REGARDLESS OF CIRCUMSTANCES! DO YOU UNDERSTAND THIS STRICT POLICY AND AGREE TO IT IN ITS ENTIRETY? THIS IS A LEGAL and BINDING CONTRACT WITH THERAPIST, HARBHAJAN S. KHALSA and PATIENT. PLEASE PRINT YOUR NAME : _____

DATE: _____ **SIGNATURE** _____

WITNESS _____

TAOS KHALSA HEALTH & KHALSA HEALTH CENTER Release Form

Manual therapy, craniosacral, visceral manipulation, consultation, assessment or other types of bodywork are not meant to replace medical diagnosis or treatment. Any suggestions given from personal experience are not considered diagnoses and will not replace the diagnoses or treatments given by your physician. If symptoms are severe or persist, please consult a physician.

I consciously agree by my own cognizance that I agreed to treatments with my therapist, Harbhajan S. Khalsa! I also understand that, by signing this statement, I am agreeing not to sue and hereby do release and hold harmless Taos Khalsa Health Center (TKHC) or any of its staff, owners, agents, landlord or insurers from all loss, liability, and damages. Also Taos Khalsa Health Center, its staff, owners, agents or insurers shall not be liable for any bodily injury, from your personal negligence or property damage that may result either directly or indirectly from attending the center.

I also understand and agree all the policies and contractual agreements of Taos Khalsa Health Center at #67 State Hwy 522, Suite B2 and C2, El Prado, NM 87514, or Khalsa Health Center at 2074 Galisteo Street, B-4, Santa Fe, NM 87505.

I have read and understand the Waiver of Liability and Informed Consent Release. By signing this form I agree to everything stated above.

Date_____ Signature_____

Witness _____