

Val Heart's BodyMind Balance Assessment™
Application and Questionnaire

*(please print clearly – if you need more space please write on another sheet and attach.
When you've completed the form, return to Val at: Fax # 210-764-0586 -- or mail to:
Val Heart, 1738 Donerail St., San Antonio, TX 78248 or email to: AskVal@valheart.com))*

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Email address _____ Age _____
Phone (home) _____ (work) _____
(cell) _____ Occupation _____
Best time/day to reach you: _____

Please Indicate your status: Married Single Divorced Separated Widowed Living with/Significant Other

1. What are the main issues you want to address?

2. What do you want to have happen as a result?

3. Do you have any active addictions or are you in recovery from addictions? If yes to either, please explain.

4. Are you a survivor of physical, sexual or emotional abuse? If yes, briefly explain your therapy process and how long you've been in recovery.

5. Are you or have you ever been suicidal? If yes, please explain.

6. Are you or have you ever taken medication for mental health problems? If yes, please explain

7. Briefly describe what you consider to be your support system.

8. List any injuries, operations or other pertinent history (use separate sheet if needed):

9. Have you been diagnosed with any medical conditions or illness?

10. Please list any medications you're currently taking:

11. Please list any vitamins or supplements that you take and why:

Instructions: Below is a list of conditions which may seem unrelated to the purpose of your session. However, there are many conditions and symptoms that are mirrored between you and your animal(s). Recognizing these underlying patterns helps us determine what these issues are so we can more consciously be aware of and address them. Please check the symptoms you have experienced as **chronic** (recurrent symptoms) and/or **acute** (symptoms you have now).

Gastro-Intestinal

Acute	Chronic	
_____	_____	Digestive Complaints
_____	_____	Stomach Pain
_____	_____	Ulcers
_____	_____	Frequent heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Frequent constipation
_____	_____	Irritable bowel
_____	_____	Hemorrhoids or rectal itching
_____	_____	Frequent vomiting
_____	_____	Colitis/Diverticulitis
_____	_____	Black or bloody stool
_____	_____	Frequent burping or belching

Immune Response

Acute	Chronic	
_____	_____	Frequently Sick
_____	_____	Frequently swollen glands/sore
_____	_____	Depression / anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild / moderate / severe)

Respiratory System

Acute	Chronic	
_____	_____	Chronic cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent colds or sinus infections
_____	_____	Recurrent bronchitis or pneumonia
_____	_____	Smoker (current or past)

Genito-Urinary System

Acute	Chronic	
_____	_____	Too frequent urination
_____	_____	Discolored or foul smelling urine
_____	_____	Blood in uring
_____	_____	Recurrent kidney or bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder
_____	_____	Recurrent urinary tract infeactions
_____	_____	Tendency to drip after urinating

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle pain
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder / Elbow / Wrist pain (circle)
_____	_____	Numbness / Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain / Hip pain (circle)
_____	_____	Joint pain or loss of function
_____	_____	Bone fractures or injury
_____	_____	Tendonitis / Bursitis

Cardiovascular

Acute	Chronic	
_____	_____	Irregular Heartbeat
_____	_____	Heart murmur / palpitations
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands & feet cold all the time

Endocrine System (glandular)

Acute	Chronic	
_____	_____	Cold hands & feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety / nervousness / irritability
_____	_____	Dizzy on standing too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive Behavior
_____	_____	Depression (occasional / mild / severe)
_____	_____	Very susceptible to infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

Eyes / Ears / Smell

Acute	Chronic	
_____	_____	Recurrent ear or eye infections
_____	_____	Slowly losing vision
_____	_____	Floaters or cloudy vision
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy
_____	_____	Yellow or red in whites of the eyes
_____	_____	Ringing or static sound in the ears
_____	_____	Earache (right or left)
_____	_____	Sensitive to bright light
_____	_____	Perfumes make you sick
_____	_____	Loss of sense of smell
_____	_____	Itchy ears or eyes

For Women Only

Acute	Chronic	
_____	_____	Recurrent yeast infections
_____	_____	Vaginal discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swings / depression
_____	_____	Premenstrual syndrome
_____	_____	Infertility
_____	_____	Frequent miscarriages
_____	_____	Sexually Transmitted Disease
_____	_____	Hot flashes
_____	_____	Currently using hormone medication
_____	_____	Lumps in breasts
_____	_____	Uterine or ovarian cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis
_____	_____	Loss of libido
_____	_____	Taking or have taken birth control pills

Have you ever been pregnant? No Yes, how many children do you have? _____
 Have you ever had an abortion? No Yes
 Have you ever lost a child? No Yes

Miscellaneous

Acute	Chronic	
_____	_____	Difficulty sleeping
_____	_____	Restless, uneasy sleep
_____	_____	Edema (legs/ankles/feet/arms/hands)
_____	_____	Unusual swelling in legs or arms
_____	_____	Chemical Sensitivities
_____	_____	Bad breath and/or body odor
_____	_____	Frequent bad dreams or nightmares
_____	_____	History of antibiotic use
_____	_____	Hair is brittle or dry
_____	_____	Poor memory
_____	_____	Crave sugar / breads / alcohol / other
_____	_____	Crave chocolate
_____	_____	Feel "spacey"
_____	_____	Frequent crying spells
_____	_____	Cuts don't heal quickly or easily
_____	_____	Frequent bruising
_____	_____	Learning Disabilities
_____	_____	Fatigue (occasional / mild / severe)
_____	_____	Are you a perfectionist?
_____	_____	Easily startled or frightened

For Men Only

Acute	Chronic	
_____	_____	Prostrate trouble
_____	_____	Urination problem
_____	_____	Reproductive problems
_____	_____	Loss of libido / impotence

Have you had a Vasectomy? Yes No
 Do you have children? No Yes, how many ____
 Have you ever lost a child? No Yes

Please list any other symptoms or unusual conditions that you feel are important:

1. _____
2. _____
3. _____
4. _____
5. _____

Please explain: _____

Toxicity Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

0 Never 1 Rarely 2 Monthly 3 Weekly 4 Daily

1. How often are strong chemicals used in your:
Home? _____ Office? _____ Kennel/stable? _____
(Includes disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax or cleaners, window/glass cleaners, etc)
2. How often are pesticides used in your:
Home? _____ Office? _____ Kennel/stable? _____
(Includes fly sprays, flea products, etc)
3. How often do you have professional treatment for insects in your:
Home? _____ Office? _____ Kennel/stable? _____
4. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your:
Home? _____ Office? _____ Kennel/stable? _____
5. How often are you exposed to nail polish, perfume, hair spray and other cosmetics?
Home? _____ Office? _____ Kennel/stable? _____
5. How often are you exposed to diesel fumes, exhaust fumes or gasoline fumes?
Home? _____ Office? _____ Kennel/stable? _____

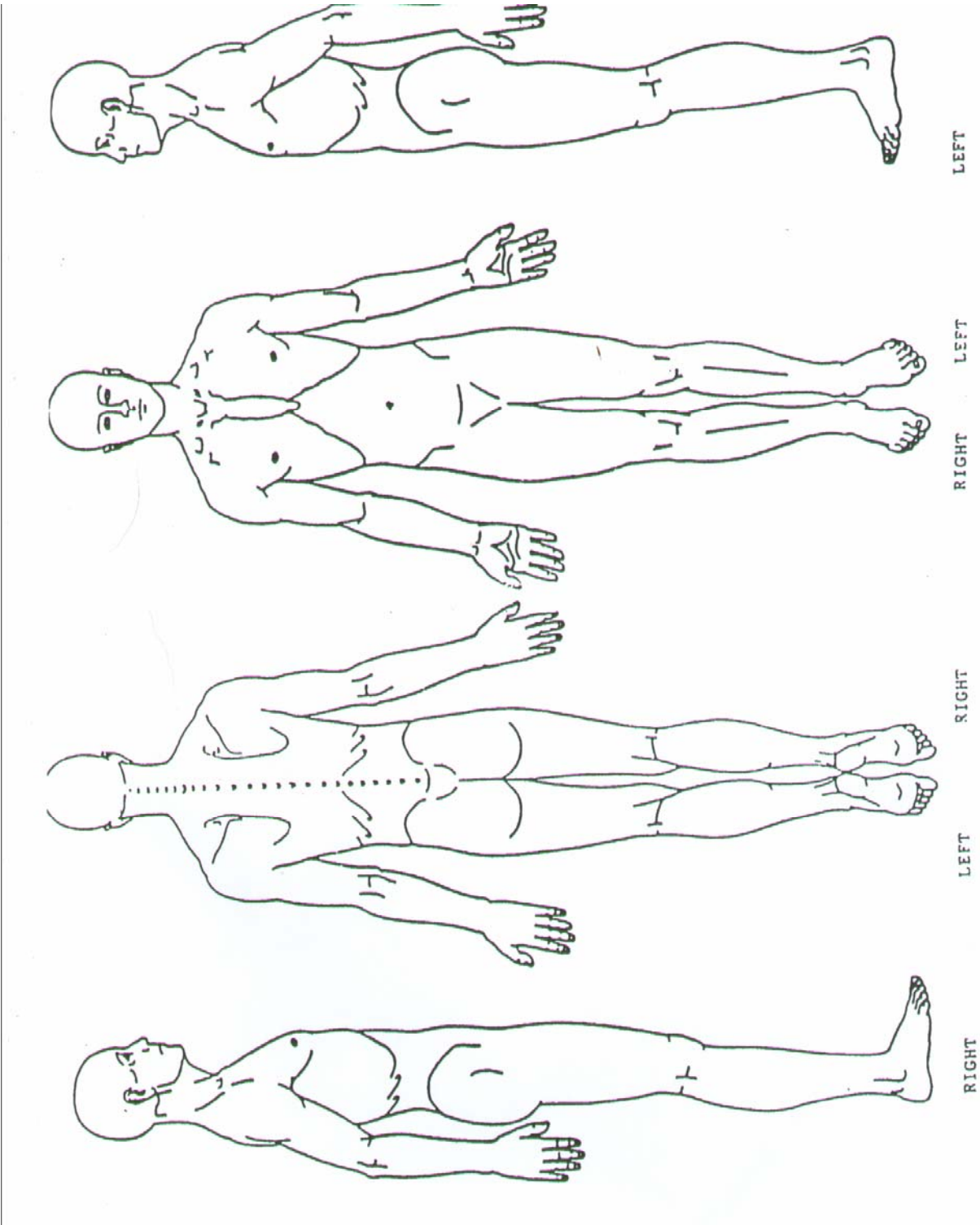
Indicate the corresponding number for questions 6 and 7 below

0 No 1 Mild Change 2 Moderate Change 3 Drastic Change

6. Have you noticed any negative change in your or your animals health since you moved into your home/partment? _____
7. Have you noticed any negative change in your health since you started your latest job? _____

Opt> For animals who are stabled or kenneled: Have you noticed any negative changes in their health after being relocated or kenneled? _____

8. Do you have a water purification system in your:
Home? NO YES, if so, what type? _____
Office? NO YES, if so, what type? _____
Kennel/Stable? NO YES, if so, what type? _____
9. Do you have any indoor pets?
NO YES, if so, how many and what kind? _____
10. Do you have an air purification system in your:
Home? NO YES, if so, what type? _____
Office? NO YES, if so, what type? _____
Kennel/Stable? NO YES, if so, what type? _____



• PLEASE SHADE IN ANY AREAS OF DISCOMFORT

CONSENT FORM FOR CONSULTING SESSIONS WITH VAL HEART, MBA, PaCBP

PLEASE take a moment to carefully read the following information and sign where indicated.

I, _____ (print your name), understand that Val's approach to health is that of a holistic nature. She addresses each individual as a unique being with diverse needs mentally, physically, emotionally and spiritually. There is no assurance that I will feel better or obtain improvement with my presenting condition(s). Val's intent is to assist me with as much ease and grace as possible in as few sessions as possible. For some this may occur in a few sessions, for others it may take longer. I am ultimately responsible for my personal healing and well-being.

If at any time I feel uncomfortable with my session, it is my responsibility to inform Val. Self-care is an extremely important part of my healing process, and I know Val respects and supports me in this. I am willing to also make appropriate lifestyle changes as needed.

I also understand that while I may immediately experience positive changes and results, I could also experience temporary difficulties as my body repairs itself. My symptoms may intensify for a short period before relief is felt, so I won't be alarmed if this happens. I will be encouraged because these symptoms tell me that the therapies are working, supporting the body as it makes changes, addressing problems more aggressively. I also agree to be patient and gentle with myself as I process and integrate these changes. If my body must create new neural pathways or generate new tissue or cells as it rebuilds healthier organs, joints, etc., this may take a few weeks or months, depending on the complexity of the task. If for any reason I am unable or unwilling to allow the time I need to heal after a therapy session, I will tell Val before our session.

I affirm that I have stated all known medical conditions, and have answered all questions honestly and to the best of my ability. I understand that this is not a substitute for medical examination and diagnosis. I understand that Val does not diagnose illness, disease or any other physical or mental disorder. Likewise, she does not prescribe medical treatments or pharmaceuticals, nor does she perform any spinal adjustments. Any information provided is for educational purposes only.

FOR DIABETICS OR ANYONE WITH HEART OR BLOOD PRESSURE PROBLEMS:

I understand that I must re-evaluate the need for insulin or other diabetic regulating protocol, or blood pressure regulatory medication(s) every day while I and/or my animal undergoes therapy because I know that the body may make fundamental changes very quickly. I hereby agree that I am willing to do so in a responsible manner.

NO SHOWS, RESCHEDULING AND CANCELLATIONS:

I understand that my appointment purchases Val's time. If I don't show up for my appointment, I still owe for her time. If I need to reschedule, I will contact her at least 48 hours before my date so that she can offer my time to someone else who needs it.

CLIENT SIGNATURE _____ DATE ____/____/____

THERAPIST SIGNATURE _____ DATE ____/____/____