[](https://hrcoftexas.com/) **CLEAR MIND PATIENT INTAKE FORM**

DATE:

NAME: DOB:

IF PATIENT IS A MINOR OR NEUROLOGICALLY COMPROMISED, PLEASE LIST THE NAME & RELATIONSHIP TO PATIENT:

BEST EMAIL & CONTACT NUMBER:

WHAT ARE YOUR PRIMARY CONCERNS FOR YOUR VISIT TODAY?

HOW LONG HAVE YOU BEEN EXPERIENCING THESE ISSUES?

LIST ANY CURRENT MEDICAL DIAGNOSIS/CONDITIONS:

ARE YOU EXPERIENCING PAIN TODAY?

HAVE YOU EVER HAD OR DO YOU EXPERIENCE SEIZURES?

HAVE YOU EVER HAD OR DO YOU EXPERIENCE REGULAR HEADACHES/MIGRAINES?

LIST ANY MAJOR TRAUMAS, ACCIDENTS, SPORTS INJURIES, FALLS, HEAD INJURIES/CONCUSSIONS:

DO YOU HAVE BRACES, PERMANENT RETAINERS, METAL IMPLANTS OR FILLINGS IN YOUR MOUTH, OR ANY RECENT DENTAL PROCEDURES? IF SO PLEASE LIST:

DO YOU WEAR HEAING AIDS? DO YOU USE AIRPODS?

ARE YOU LIGHT SENSITIVE?

WHAT TIME DO YOU GO TO BED AT NIGHT? DO YOU SLEEP WITH YOUR PHONE?

DO YOU GET 7-8 GOOD HOURS OF SLEEP PER NIGHT?

DO YOU PLAY VIDEO GAMES AT NIGHT BEFORE BED (OR LATE DURING THE NIGHT)?

DO YOU DRINK SPORTS/ENERGY DRINKS, CAFFEINATED BEVERAGES? IF SO, WHICH AND HOW MUCH PER DAY/WEEK?

DO YOU DRINK ALCOHOL? IF SO, HOW MUCH PER DAY/WEEK?

DO YOU USE TOBACCO? IF SO, WHAT TYPE/HOW MUCH PER DAY?

HAVE YOU EVER OR DO YOU CURRENTLYU USE MARIJUANA, CBD, OR KRATOM? IF SO, WHICH/HOW MUCH PER DAY/WEEK?

HAVE YOU EVER OR DO YOU CURRENTLY USE ILLICIT DRUGS? IF SO WHICH/HOW MUCH PER DAY/WEEK?

LIST ANY/ALL MEDICATIONS (ATTACH EXTRA SHEET OR WRITE ON BACK OF THIS FORM IF NEED):

WHICH IF ANY OF THESE MEDICATIONS DID YOU TAKE PRIOR TO THIS VISIT TODAY? ***CIRCLE THE ONES YOU TOOK***

ARE YOU FULLY, PARTIALLY OR NOT VACCINATED?

DO YOU GET ANNUAL FLU/OTHER VACCINES? HAVE YOU HAD THE HPV VACCINE(S)?

HAVE YOU HAD COVID? IF SO, HOW LONG AGO?

HAVE YOU HAD THE COVID VACCINE(S) IF SO, WHICH?

**HIPPA Release Form**

**Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.**

**Section I**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** give my permission for **Health Resource Center** to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

**Section II – Health Information**

I would like to give Health Resource Center permission to:

*(Initial)* \_\_\_\_\_\_\_Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

**Forms of Disclosure:**

*(Initial)* \_\_\_\_\_\_Electronic copy

*(Initial)* \_\_\_\_\_\_Hard copy

*(Initial)* \_\_\_\_\_\_Phone Call

*(Initial)* \_\_\_\_\_\_May leave voice mail or text

*(Initial)* \_\_\_\_\_\_In Person consult

**Section III – Who Can Receive My Health Information**

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization (If any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization (If any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization (If any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

**Section IV – Duration of Authorization**

This authorization to share my health information is valid from the date signed below until I revoke this authorization to share my health data and can do so any time by submitting a request in writing to **Health Resource Center**:

**Section V – Signature**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this form is being completed by a person with legal authority to act an individual’s behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe below how this person has legal authority to sign this form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Liability/Express Assumption of Risk**

**Consent for Therapy and Waiver of Liability**

In consideration of being allowed to participate as a client in Shine Through and/or Health Resource Center, I do hereby waive, release, and forever discharge the therapist from any and all claims, responsibilities, liabilities, injuries, actions, or causes of action arising from the therapy hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the therapist, to the fullest extent allowed by law. In my participation in the activities of these techniques, I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my safe participation in the activities of the therapy. However, knowing the material risks and appreciating, knowing, and reasonably anticipating that injuries are a possibility, I hereby expressly assume all of the delineated risks of injury, all other possible risks of injury or death, which occur by reason of my participation.

I have had the opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I understand that this is designed to be an ancillary health aid and not suitable for primary medical treatment for any condition. I subjectively understand the risks of my participation in this activity and, knowing and appreciating these risks, I voluntarily choose to participate, assuming all risks of injury or even death due to my participation. I understand and agree that this consent will apply to and govern the current and all future therapy sessions performed by the therapist.

Client Signature Client Printed Name Date

Witness Signature Witness Printed Name Date