

Four Directions Healing Tools  
Bek Wiltbank, MOTR/L  
12911 120th Avenue NE, Ste E-50  
Kirkland, WA 98034  
206.391.6721  
425.820.7707 - Fax

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_

Emergency Contact & Phone \_\_\_\_\_

### Current Health

Exercise level: \_\_\_ active \_\_\_ moderate \_\_\_ light \_\_\_ no exercise

Nutritional habits: # vegetables per day \_\_\_\_\_ # fruits per day \_\_\_\_\_ whole grains \_\_\_\_\_

WATER:oz. per day \_\_\_\_\_ supplements \_\_\_\_\_

Allergies: \_\_\_\_\_

### Birth and Infancy History (What your parents may have told you):

\_\_\_ Caesarian delivery      \_\_\_ Forceps or vacuum suction delivery

\_\_\_ Breast fed      \_\_\_ Bottle fed      \_\_\_ Ear inflammations/infections

\_\_\_ Sucked thumb      \_\_\_ Used pacifier      \_\_\_ Teeth Grinding

\_\_\_ Frequent illnesses      \_\_\_ Vaccinations: \_\_\_\_\_

\_\_\_ Falls, after which you lost consciousness

Age you began walking \_\_\_\_\_

Age you began talking \_\_\_\_\_

**Health History Questionnaire**

Current health concerns (in order of importance)

Date of onset

- 1.
- 2.
- 3.
- 4.

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Have you ever had CranioSacral Therapy?

What brings you to craniosacral therapy? What do you hope for with treatment:

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What factors do you feel are contributing to your current state of health?

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Primary Care Physician:

Phone number:

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Other health care practitioners (i.e. medical specialists, acupuncturist, chiropractor, counselor, other specialists)

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Any medical diagnoses: \_\_\_\_\_

Please list and include dates if possible:

• Surgeries: \_\_\_\_\_

• Accidents/Injuries: \_\_\_\_\_

• Major Illnesses/Hospitalizations: \_\_\_\_\_

Please mark any of the following conditions you have now or have significant history of in the past.

General

Current Past	Description
<input type="checkbox"/>	<input type="checkbox"/> Headaches: _____
<input type="checkbox"/>	<input type="checkbox"/> Pain: _____
<input type="checkbox"/>	<input type="checkbox"/> Sleep Disturbance: _____
<input type="checkbox"/>	<input type="checkbox"/> Fatigue: _____
<input type="checkbox"/>	<input type="checkbox"/> Sinusitis: _____
<input type="checkbox"/>	<input type="checkbox"/> Other: _____

Muscles and Joints

Current Past	Description
<input type="checkbox"/>	<input type="checkbox"/> Bone or Joint Disease: _____
<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis: _____
<input type="checkbox"/>	<input type="checkbox"/> Broken Bones: _____
<input type="checkbox"/>	<input type="checkbox"/> Tendonitis/Bursitis: _____
<input type="checkbox"/>	<input type="checkbox"/> Arthritis: _____
<input type="checkbox"/>	<input type="checkbox"/> Scoliosis: _____
<input type="checkbox"/>	<input type="checkbox"/> Disc Problems: _____
<input type="checkbox"/>	<input type="checkbox"/> Lupus: _____
<input type="checkbox"/>	<input type="checkbox"/> Sprain/Strain: _____
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain/TMJ: _____
<input type="checkbox"/>	<input type="checkbox"/> Neck/Shoulder/Arm Pain: _____
<input type="checkbox"/>	<input type="checkbox"/> Hip/Low back Pain: _____
<input type="checkbox"/>	<input type="checkbox"/> Knee/Ankle Pain: _____

Nervous System

Current Past	Description
<input type="checkbox"/>	<input type="checkbox"/> Head injuries/Concussions: _____
<input type="checkbox"/>	<input type="checkbox"/> Dizziness/Ringing in ears: _____
<input type="checkbox"/>	<input type="checkbox"/> Numbness/Tingling: _____
<input type="checkbox"/>	<input type="checkbox"/> Sciatica/Shooting pains: _____
<input type="checkbox"/>	<input type="checkbox"/> Pinched Nerve: _____
<input type="checkbox"/>	<input type="checkbox"/> Bell's Palsy: _____
<input type="checkbox"/>	<input type="checkbox"/> Other: _____

Endocrine System

Current Past	Description
<input type="checkbox"/>	<input type="checkbox"/> Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/> Thyroid Condition: _____
<input type="checkbox"/>	<input type="checkbox"/> Other: _____

Respiratory/Cardiovascular

Current Past

Description

- Heart Condition: \_\_\_\_\_
- Blood Clots: \_\_\_\_\_
- High/Low Blood Pressure: \_\_\_\_\_
- Stroke: \_\_\_\_\_
- Irregular Heart Beat: \_\_\_\_\_
- Poor Circulation: \_\_\_\_\_
- Edema/Swollen Ankles: \_\_\_\_\_
- Chest Pain/Short of Breath: \_\_\_\_\_
- Asthma: \_\_\_\_\_

Digestive/Elimination System

Current Past

Description

- Constipation/Diarrhea: \_\_\_\_\_
- Gas/Bloating: \_\_\_\_\_
- Irritable Bowel Syndrome: \_\_\_\_\_
- Gastric Ulcers: \_\_\_\_\_
- Bladder/Kidney Dysfunction: \_\_\_\_\_
- Other: \_\_\_\_\_

Reproductive

Current Past

Description

- Pregnancy: \_\_\_\_\_
- Menstrual problems: \_\_\_\_\_
- Prostate problems: \_\_\_\_\_
- Other: \_\_\_\_\_

Other

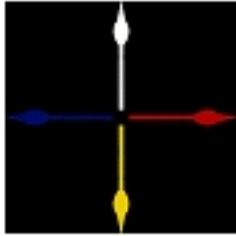
Current Past

Description

- Cancer: \_\_\_\_\_
- Anxiety/Stress: \_\_\_\_\_
- Tobacco Use: \_\_\_\_\_
- Drugs: \_\_\_\_\_
- Alcohol. Drinks/week: \_\_\_\_\_
- Other: \_\_\_\_\_

I confirm that the above information is true, accurate, and complete, to the best of my knowledge.

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



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Informed Consent for Treatment  
Craniosacral Therapy

I, \_\_\_\_\_, hereby authorize Bek Wiltbank, MOTR/L to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Craniosacral Therapy

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the therapist if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

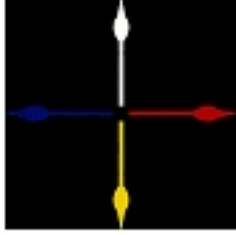
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Bek Wiltbank, MOTR/L regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Bek Wiltbank, MOTR/L to the best of her ability.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient Representative OR Guardian



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Please read the following financial and fee policy prior to your visit. If you have any questions or need clarification, please feel free to ask.

1. Payment policy

Payment in full is required at the time of service. The therapy rate is \$100- 1 hour

The therapy hour, as is industry standard, is 50 minutes.

Four Directions Healing Tools accepts cash or checks.

Please make checks out to Bek Wiltbank.

2. Cancellation and no-show policy

Bek Wiltbank, MOTR/L requires a minimum of 24-hours notice if canceling an appointment. If it is not an emergency situation, and you cancel less than 24-hours before your scheduled appointment, you may be charged for the missed appointment.

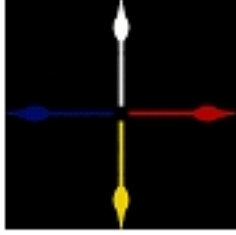
I acknowledge that I have read and fully understand this financial and fee policy. I agree to the above stated fees and charges. All of my questions have been answered.

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Date

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Signature of Patient or responsible party



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Craniosacral Therapy  
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your Health Information

Each time you visit your healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health or medical professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Understanding of what is in your record and how your health information is used to help you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health information is the physical property of your healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the "Notice of Privacy Practices" upon request
- Inspect and copy your health records
- Request an amendment of your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

The physicians and staff at Bek Wiltbank's Office are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate health information by alternative locations

#### How We Use your Health Information

- We will use your health information for TREATMENT

Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding

- We will use your health information for PAYMENT

Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

- We will use your health information for HEALTH CARE OPERATIONS

Example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

#### Other Ways That We May Use your Health Information

- Business Associates: There are some services provided in our organization through contracts with Business Associates, including: diagnostic services and laboratory tests. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.
- Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

#### To Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with Bek Wiltbank, MOTR/L. We will investigate all complaints and there will be no retaliation for filing a complaint. You may also file a written complaint with the Secretary of Health and Human Services.