

# **Application for Treatment & Confidential Case History**

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Please ...

1. Print this document (if downloading it from the Internet),
2. Fill it out,
3. And bring the completed form with you to your first appointment.

**Thank You!**

*Application revised November 21, 2004*

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Wellness Images' therapy program involves Structural Bodywork and Holistic Coaching. An individual's program may consist of bodywork alone, coaching alone, or a combination of approaches. Experience shows that bodywork and coaching combined are often most effective.

## Structural Bodywork

Goals: Restore balanced body posture by targeted manual therapy to specific tissues that, when overly contracted, cause misalignment. Techniques include tissue compression, gliding strokes, myofascial release, manual traction, hot and cold contrast therapy, stretching, therapeutic movement, and range of motion. We re-educate the body about its proper position in space.

Effects of re-alignment include:

- Less destructive mechanical force on joints and soft tissues, promoting their longevity
- Relief of pain and discomfort
- Less energy required for daily activities, enhancing performance and relieving fatigue

Limitations: Structural bodywork alone will not address lifestyle, medical, or anatomical factors that cause, contribute to, or perpetuate poor body alignment.

## Holistic Coaching

Goals: Identify and address lifestyle factors that interfere with the client's desire for life satisfaction and optimal health. In addition to general health and satisfaction, these factors may contribute to physical tension patterns and body alignment. The practitioner guides the client with techniques and strategies to set and achieve appropriate goals.

Limitations: (1) Additional expertise may be required. The client may be encouraged to consult with issue-specific professionals and resources. (2) The client is responsible for carrying out goal-related actions. This process can easily be sabotaged or abandoned by the client. (3) Coaching alone may not address physical stress patterns already manifest in the body tissues.

## Phases of Therapy for Bodywork Clients

In addressing your therapeutic goals, you'll want to arrange a program that will bring about the best results. Your needs will change as you progress. You should expect to progress through an **acute phase**, an **active phase**, and a **maintenance phase**. Remember that you are the expert on your life and must ultimately choose what you need for yourself.

- When you first arrive, your first interest is typically relieving troubling symptoms as quickly as possible. Your situation is **acute** (intense, urgent). We assess your situation, consider your concerns, and develop an initial strategy. The **acute phase** of therapy works best for most people at a treatment interval of one week or less between appointments.
- As your symptoms resolve, your therapeutic goals change. In the **active phase** of therapy, our focus shifts to optimizing results. The more thoroughly we address the cause behind your symptoms, the less likely they are to come right back. The **active phase** of therapy works best for most people at a treatment interval of one to three weeks.
- When we've satisfactorily addressed the cause behind your symptoms, you'll shift into a **maintenance phase**. Since we are dynamic beings (having movement), challenges may surface again. Your best **maintenance interval** may vary from one to six months, depending on your challenges and lifestyle.

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## General Information

Name \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ e-mail \_\_\_\_\_  
State/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Primary Occupation \_\_\_\_\_  
Other activities, hobbies, sports \_\_\_\_\_  
In case of emergency, notify \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Relationship to you \_\_\_\_\_  
Who can we thank for referring you to our clinic? \_\_\_\_\_

## Your Therapeutic Goals

What is the outcome you most desire as a result of your therapy here? \_\_\_\_\_  
\_\_\_\_\_

Do you believe that this outcome is possible?

\_\_\_\_ Yes      \_\_\_\_ No      \_\_\_\_ Not sure

We define a symptom as "anything you don't like." Examples include physical pain, discomfort, lack of satisfaction in life, etc. The next several questions refer to your symptoms.

- Please identify your most troubling symptom: \_\_\_\_\_  
When is the first time you remember noticing it? \_\_\_\_\_  
How often does it bother you? Constantly \_\_\_\_ Daily \_\_\_\_ Weekly \_\_\_\_ Occasionally \_\_\_\_  
On a scale of 1 (mild) to 10 (severe), how intense is it? \_\_\_\_  
How long does it last? \_\_\_\_\_  
What do you think is causing it? \_\_\_\_\_
- If you have a second symptom, please identify it: \_\_\_\_\_  
When is the first time you remember noticing it? \_\_\_\_\_  
How often does it bother you? Constantly \_\_\_\_ Daily \_\_\_\_ Weekly \_\_\_\_ Occasionally \_\_\_\_  
On a scale of 1 (mild) to 10 (severe), how intense is it? \_\_\_\_  
How long does it last? \_\_\_\_\_  
What do you think is causing it? \_\_\_\_\_
- If you have a third symptom, please identify it: \_\_\_\_\_  
When is the first time you remember noticing it? \_\_\_\_\_  
How often does it bother you? Constantly \_\_\_\_ Daily \_\_\_\_ Weekly \_\_\_\_ Occasionally \_\_\_\_  
On a scale of 1 (mild) to 10 (severe), how intense is it? \_\_\_\_  
How long does it last? \_\_\_\_\_  
What do you think is causing it? \_\_\_\_\_

Please describe any additional symptoms that bother you: \_\_\_\_\_  
\_\_\_\_\_

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One factor that distinguishes our therapy program from others is that we aim to identify and address the cause behind your symptoms. This inquiry works best as a joint venture between you (the expert on your life) and your therapist (the expert on our program). The next several questions relate to your willingness to participate in resolving your problem.

- If you believed that becoming more conscious about your repetitive movement or thought habits would make a difference in resolving your symptoms, would you be willing to give them your attention? \_\_\_ Yes  
\_\_\_ No  
\_\_\_ Not sure
- If you believed that educating yourself about your situation would make a difference in resolving your symptoms, would you be willing to read a book, listen to an audio program, or participate in a class? \_\_\_ Yes  
\_\_\_ No  
\_\_\_ Not sure
- If you believed that practicing stretching, therapeutic movement, or conscious thought choices would make a difference in resolving your symptoms, would you be willing to include them in your schedule? \_\_\_ Yes  
\_\_\_ No  
\_\_\_ Not sure
- If you believed that addressing lifestyle factors like taking in toxic substances, your sense of purpose in life, or your relationships with others would make a difference in resolving your symptoms, would you be willing to give them your attention? \_\_\_ Yes  
\_\_\_ No  
\_\_\_ Not sure

### Your Health History

When did you last see a medical doctor for your condition? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ City: \_\_\_\_\_

Are you under the care of a chiropractor? \_\_\_ If so, who? \_\_\_\_\_

Are you under the care of a mental health professional? \_\_\_ If so, who? \_\_\_\_\_

Please mark any of the following conditions that may affect your health at this time:

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>___ Arthritis</li> <li>___ Breathing problems</li> <li>___ Caffeine consumption</li> <li>___ Cancer</li> <li>___ Depression</li> <li>___ Diabetes</li> <li>___ Digestive problems</li> <li>___ Dizziness or vertigo</li> <li>___ Drug or alcohol use</li> <li>___ Endometriosis</li> <li>___ Eye conditions</li> <li>___ Fatigue</li> <li>___ Heart problems</li> <li>___ Heartburn</li> </ul> | <ul style="list-style-type: none"> <li>___ High blood pressure</li> <li>___ Immune system problem</li> <li>___ Mental health problems</li> <li>___ Menstrual problems</li> <li>___ Multiple Sclerosis</li> <li>___ Nightmares</li> <li>Pain or discomfort in:               <ul style="list-style-type: none"> <li>___ Back</li> <li>___ Neck</li> <li>___ Head (headache)</li> <li>___ Arms or shoulders</li> <li>___ Legs or hips</li> <li>___ Other _____</li> </ul> </li> <li>___ Parkinson's disease</li> </ul> | <ul style="list-style-type: none"> <li>___ Pregnant</li> <li>___ Past pregnancies (#) ___</li> <li>___ Ringing in ears/tinnitus</li> <li>___ Seizures</li> <li>___ Skin problems or rash</li> <li>___ Sleep disorders</li> <li>___ Snoring</li> <li>___ Spinal problems</li> <li>___ Sugar consumption</li> <li>___ Thyroid problems</li> <li>___ TMJ dysfunction</li> <li>___ Tobacco use</li> <li>___ Urinary problems</li> <li>___ Varicose veins</li> </ul> |
|---|--|---|

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Please list your prescribed medications (attach a separate page if you prefer):

- Medication \_\_\_\_\_ Condition Treated \_\_\_\_\_
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- Medication \_\_\_\_\_ Condition Treated \_\_\_\_\_

What non-prescribed medicines or supplements do you take regularly? \_\_\_\_\_

- Do you wear orthotics (shoe inserts)? \_\_\_\_\_ yes \_\_\_\_\_ no
- Do you wear glasses or contact lenses? \_\_\_\_\_ yes \_\_\_\_\_ no
- Any dental appliances (dentures, bite splint, etc.)? \_\_\_\_\_ yes \_\_\_\_\_ no
- Are you allergic to latex? \_\_\_\_\_ yes \_\_\_\_\_ no

List any other allergies: \_\_\_\_\_

Describe any surgeries, even if they were years ago: \_\_\_\_\_

Describe any accidents, even if they were years ago. Include athletic injuries, falls, etc., in addition to motor vehicle accidents: \_\_\_\_\_

Please briefly summarize what you know about your own birth experience: \_\_\_\_\_

What else would help us understand your lifestyle or condition? \_\_\_\_\_

### **Training Disclosure:** Credentials for Elizabeth Eckert

#### Academic

- PhD degree in Energy Medicine jointly granted by Greenwich University and Holos University, MO (2001).
- MA degree in Psychology: Human Development granted by Wayne State University, Detroit, MI (1991).
- BM degree in Music Education and Composition granted by Bowling Green State University, OH (1980).

#### Therapeutic Bodywork

- Teaching staff, St. John Neuromuscular Therapy Seminars (1994-2004).
- North Dakota state license to practice massage therapy (2001).
- Researcher, Henry Ford Hospital, Detroit, MI (1999-2000); investigating St. John Therapy and headaches.
- Nationally Certified in Therapeutic Massage and Bodywork (1998).
- Neuromuscular therapy certificate; St. John Seminars, Pinellas Park, FL (1994).
- Massage therapy certificate (1000 hr); Health Enrichment Center, Lapeer, MI (1990).

#### Additional Certificate Programs

- Completed 2 courses with Dr. Doreen Virtue in intuition development (2003).
- Completed 5 courses with Drs. Caroline Myss and C. Norman Shealy in medical intuition (1996-2001).
- 2 certificates in Transformational Breathwork; Transformations, Inc, Milwaukee, WI (1999, 2000).
- Completed 11 courses with Tom Brown, Jr. in applied philosophy of living with the earth (1994-2000).
- Shodan rank (1st degree black belt) in Koei-Kan Karate-Do (1998) and 3 additional years of study.

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## Terms of Service

**1. Permission to release or exchange information** *(Required if you were referred by another health practitioner or if your services may be reimbursed by any third party such as an insurance carrier.)*

You are authorized to release and request information, including treatment records and history obtained, to and from the parties listed:

- Party #1 \_\_\_\_\_ Your signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_
- Party #2 \_\_\_\_\_ Your signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_
- Party #3 \_\_\_\_\_ Your signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## 2. Financial Responsibility

I claim full responsibility for the services rendered by Wellness Images for (print client's name) \_\_\_\_\_ and understand that payment in full is required at the time of service. I understand that Wellness Images does not do third party billing. I understand that most insurance companies do not reimburse for the services provided here.

I understand that time scheduled for treatment or consultation is reserved for me and that the full fee will be charged unless I change or cancel an appointment at least 24 hours in advance.

## 3. Informed Consent - Structural Bodywork

I consent to structural bodywork (also called neuromuscular therapy) as an application of massage therapy. I understand that treatment given here is for the purpose of relief from muscular tension or for increasing circulation or energy flow. The practitioner does not diagnose any physical or mental disorder or illness, does not prescribe medical treatment or pharmaceuticals, and does not perform spinal manipulations. Response to therapy differs by individual and specific results cannot be guaranteed. I understand that this therapy is not a substitute for medical examinations and/or diagnosis, and that I am advised to see a physician for any physical ailments. I have stated all my known medical conditions and agree to keep the therapist updated on my health.

## 4. Informed Consent - Holistic Coaching

I consent to an educational process designed to identify and address lifestyle challenges that may affect my health and well-being. I understand that the practitioner is an educator and not a licensed mental health provider. I understand that it is natural, in exploring beliefs and habits, to experience temporary feelings such as anxiety, frustration, fear, or anger. I understand that if my emotional responses concern me, become overwhelming, or interfere with my ability to perform daily activities, I am advised to communicate this to the practitioner and consult a licensed mental health provider.

I have read and completed the treatment application and case history to the best of my ability. I agree to the terms of service stated above.

\_\_\_\_\_  
Your signature; or the signature of your parent or guardian if you are under 18 years of age. Date \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Please print the name of the person whose signature appears above.

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