**Kendra L. Moore**

Owner, LMT, CST, CPEH

Energy Balancing, LLC

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**INFORMED CONSENT FOR BIOFEEDBACK TRAINING**

**MY BACKGROUND**

*I am a Holistic Health Care Advisor, Certified/Licensed Massage Therapist, CMT, LMT, Cranio-Sacral Therapist, CST, Reiki and Integrated Energy certified Master Instructor, Certified Practitioner for Esoteric Healing with the National Association of Esoteric Healing (NAEH), CPEH and a Certified Practitioner and Instructor with the International Network for Energy Healing (INEH), CPEH.*

I am not licensed a physician, psychologist or chiropractor, and I cannot and will not diagnose, treat, cure, mitigate or prevent any medical or psychological disease, disorder or condition.

**BIOFEEDBACK**

Biofeedback is a complementary and alternative medicine technique which enables an individual to learn to change some physiological activities for the purpose of improving health. With biofeedback, the subject is connected to the biofeedback device with sensors to measure and receive information (feedback) about the body (bio). The biofeedback sensors use mild electrical impulses that measure skin temperature known as Electro Dermal Response (EDR), which teaches the individual to make subtle bodily changes, such as relaxing certain muscles, to achieve desired results, such as reducing pain. Biofeedback is often used as a relaxation technique.

The instrument utilized in the training sessions is called the SCIO biofeedback system, which requires that the client connect to the system with a head band, ankle and wrist straps to measure EDR. The scope of my practice through the use of this biofeedback system includes stress reduction training programs for relaxation training, pain management, muscle re-education and brainwave training. Although this training is expected to produce beneficial results, such results cannot be guaranteed. Biofeedback training is a complement, not a substitute, for medical or psychological treatment, and any ongoing treatment should not be discontinued without advice of your treating physician.

**CONFIDENTIALITY**

Client information will be kept in confidence and will not be disclosed to anyone outside of this office without your written consent, unless as is required by law.

**ARBITRATION PROVISION** I hereby acknowledge and understand that I have been granted permission to participate in training, events, activities, or services (hereinafter collectively referred to as “Services”) conducted by Energy Balancing, Energy Balancing LLC, Energy Balancing Alternative and Holistic Wellness Center. These trainings, events, activities, and services include but are not limited to Biofeedback, aromatherapy, massage, bio-energetics and energy healing. In consideration of the grant of my permission for me to participate in the services and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, I hereby acknowledge and agree and represent as follows:

1. I am in good health and have no impairment, medical condition, illness or health related issue which may prevent me from engaging in any Services. I assume full responsibility for my medical condition as it relates to engaging in the Services. I have consulted with a physician and have not been instructed by such physician to refrain from participating in any Services.
2. If at any time I become aware of impairment, medical condition, illness or health related issue that may impact my ability to participate in the Services, I will immediately inform Energy Balancing of the change in my health status.
3. I acknowledge and agree that my participation in the Services at Energy Balancing is at the sole discretion of Energy Balancing and that I will be required to submit a physician’s note permitting continued use of the Services is requested by Energy Balancing.
4. I understand that my participation in the Services conducted by energy Balancing may involve risk, including, but not limited to serious injury including bodily injury, damage to personal property, and death. I hereby knowingly and freely assume all risk and responsibility for any and all damage to property (including costs of replacement or repair) or bodily and/or personal injury (including all medical expenses), including death, in connection with my participation in the Services conducted by Energy Balancing.
5. I hereby release, discharge and covenant not to sue (and relinquish my rights to sue) Energy Balancing, its Board of Directors, officers, shareholders, agents (including managing agent) employees, attorneys, their respective successors and/or assigns and all landowners (all “additional Party”) from and with respect to any and all liability, claims, demands, actions, suits, rights and/or causes of action of whatever kind or nature, now or hereafter existing, whether known or unknown, present or future, foreseen or unforeseen, whether caused by the negligence of Energy Balancing or an Additional Party or otherwise, that may arise from my participation in the Service’s including, without limitation, any damage to property or bodily and/or personal injury in connection therewith. I hereby waive any protections afforded by any statute or law in any jurisdiction whose purpose substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise, which person giving the release does not know or suspect to exist at the time of executing the release. This means, in part, that I am hereby releasing any and all unknown future claims.
6. I agree to indemnify and hold harmless Energy Balancing and all Additional Party(s) from and against any loss, damage, claim, suit, liability, demand, cost and/or expense, paid or incurred by Energy Balancing or an Additional Party, or asserted against any of them (including attorney’s fees, court costs and disbursements) caused in whole or in part, by, or arising directly or indirectly out of my participation in the Services and /or my breach of this Waiver and Release from Liability.
7. Energy Balancing has advised me not to bring personal property to Energy Balancing’s physical location. I assume full responsibility for any loss of or damage to my personal property which may occur on-site. Energy Balancing nor any Additional Party shall not be liable for the loss, theft, or damage of any personal property located anywhere on-site.
8. Energy Balancing or an Additional Party may repair, at my expense, all damage to Energy Balancing’s physical location caused by me, and I agree to pay Energy Balancing or an Additional Party on demand any amounts so expended.
9. This Waiver and Release from Liability covers any and all liability, claims and actions caused entirely, or in part, by any and all acts or failures to act on my part, including but not limited to, negligence or mistake.
10. This Waiver and Release from Liability shall also bind my assigns, heirs, executors, administrators, distributes, guardians and next of kin.
11. This waiver and Release from Liability shall be governed by the laws of Indiana. Any Suit, action, or dispute arising out of this Waiver and Release from Liability shall be brought in Bartholomew County, Indiana.
12. If any term or provision of this Waiver and Release from Liability is held to be illegal, invalid or unenforceable it is the express intention of the parties that the remainder of this Waiver and Release from Liability shall not be affected thereby, and each term, clause or provision of this Waiver and Release from Liability, and the application thereof, shall be legal, valid and enforceable to the fullest extent permitted by law.
13. This Waiver and Release from Liability constitutes the entire agreement of the parties with respect to this subject matter supersedes all prior agreements, understandings, negotiations, statements, promises and discussions, oral and written, between the parties hereto with respect to the subject matter of this Waiver and Release from Liability.
14. I have read and fully understand the terms of this Waiver and Release from Liability, and that I may have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement.

**CONSENT**

Your signature below indicates that you have read and understood the information in this document and that you consent to biofeedback training under the provisions stated. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing.

**CONSENT TO TREATMENT AND PRIVATE CONTRACT TO TREATMENT**

Holistic Health Advisors (HHA’s) are not Medical Doctors (MD’s). I understand that I should continue to see any medical doctors I am currently under the care of, and that any prescription medication should not be altered without first consulting the Medical Doctor. Energy Balancing, LLC/Kendra L. Moore will not diagnose or treat any known or unknown condition, nor make statements that might tend to show intent to prescribe any medication for the treatment of a known or unknown condition.

We, the undersigned, hereby acknowledge that the business of Energy Balancing, LLC/Kendra L. Moore, consists of non-invasive natural remedies, such as vitamins, minerals, herbs and dietary changes to create a healthy environment in the body, and various bodywork modalities, such as Massage Therapy, but not limited to such. Your visit today is based on the belief that the body has a natural ability to heal itself, if given an appropriate internal and external healing environment. Nothing said, done, typed, printed or reproduced by us is intended to diagnose, prescribe, treat or take the place of a licensed physician.

I agree that Energy Balancing, LLC/Kendra L. Moore assumes no responsibility for my actions, or for the results of any action I may take with regard to recommendations made during the time period with which Energy Balancing, LLC/Kendra L. Moore is retained in the capacity of a Holistic Health Advisor. I also attest that I am solely seeking treatment with Energy Balancing LLC/Kendra L. Moore, on my own behalf, and not as an agent or representative of any Federal, State, County, Local Agency, or any Independent Doctor’s Office on a mission of entrapment or investigation on behalf of these or any other agencies, either on this or any subsequent visit.

I understand that I am responsible and accountable for all charges incurred, and any subsequent interest and/or past due charges for unpaid balances, including any charges for collecting on all ‘past due’ bills. Due to Federal Regulations, opened supplements cannot be returned for a refund.

The signatures below signify a contract that is not subject to change or adjustment by any non-vested party. My signature below indicates that I have read all of the above statements and that I accept and understand them completely. I agree to consult with Energy Balancing, LLC/Kendra L. Moore on these terms.

Client Signature Print Name @ Birth Name Date

Birth City and State Time of Birth Email Address

Phone Number: Date of Birth: Weight Height:

Address City State Zip Code

**FOR PARENTS/GUARDIANS OF MINOR CLIENT**

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo biofeedback training.

Parent/Guardian's Signature Minor’s Name Date

**HIPPA AUTHORIZATION:**

I AUTHORIZE KENDRA L. MOORE, TO DISCLOSE OR OBTAIN MY INFORMATION FROM MY SESSIONS, WITH THE FOLLOWING PEOPLE. I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO KENDRA MOORE. I RESERVE THE RIGHT TO DISCLOSE INFORMATION AS PERMITTED BY THIS AUTHORIZATION IN ANY MANNER THAT WE DEEM TO BE APPROPRIATE AND CONSISTENT WITH APPLICABLE LAW, INCLUDING, BUT NOT LIMITED TO, VERBALLY.

**NAME OF PERSON**

**SYMPTOM SURVEY FORM**

**Please List your three main physical concerns**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_NO Do you currently have a pacemaker?

\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No Do you currently have a tens unit?

\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No Are you currently Pregnant?

\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No Do you currently or have you in the past had a Seizure?

What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hours per week:\_\_\_\_\_\_\_\_\_

Do you have children? How many \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any C-sections? \_\_\_\_\_\_\_\_\_\_\_\_\_(females)

Do you have or suspect any food allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City or Farm/Ranch?\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise 3 or more times per week? \_\_\_\_\_\_\_\_\_\_\_\_ Type of exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken medication for acne? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, please list them below:

Have you been given a diagnosis/name for your “dis-ease”? If so, please list below:

Are you currently taking any prescription or over-the-counter drugs? If so, please list below:

**REMEMBER TO BRING A LIST OR ALL MEDICATIONS & SUPPLIMENTS WITH YOU FOR EACH APPOINTMENT**

For each question, circle the number that best describes your symptoms, **if it does not apply to you just leave the question blank:**

**1 = Occasionally**

**2 = Often** - Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it!

**3 = Frequently**—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

**Some questions require a YES or NO response**

|  |  |  |  |
| --- | --- | --- | --- |
| **Bowel/Digestion** |  | **Liver/Gallbladder** |  |
| Indigestion or Heart Burn | **1 2 3** | Skin peels on feet or you have burning feet. | **Yes No** |
| Belching and/or Bloating after meals | **1 2 3** | Frequent headaches? | **Yes No** |
| Do you use antacids or a prescription for acid reflux? | **Yes No** | Use of Tylenol (acetaminophen) on a regular basis - at least once per week. | **Yes No** |
| Diarrhea (loose, unformed stool) | **1 2 3** | Do you get migraines? | **Yes No** |
| Alternating constipation/diarrhea | **1 2 3** | Hay fever or seasonal allergies? | **Yes No** |
| Constipation (less than one stool movement per day- or straining) | **1 2 3** | Greasy foods upset? | **Yes No** |
| Do you have colitis, or irritable bowels? | **Yes No** | Do you have a gallbladder? | **Yes No** |
| Bowel movements shortly after eating (within one hour) | **Yes No** | Frequent skin rashes/eczema? | **Yes No** |
| Pass mucus in your stool! | **1 2 3** | Have you had hemorrhoids? | **Yes No** |
| Rectal/anal itching or burning? | **Yes No** | Do you have tenderness under your ribs on the right side of your body? | **Yes No** |
| Have you ever had food poisoning? | **Yes No** | Have you ever had a gallbladder attack? | **Yes No** |
| How many antibiotics have you used in the last 5 years? | **#** | How many flu vaccinations have you received? | **#** |
| Have you had any yeast infections? | **Yes No** | Do you get cold sores or herpes outbreaks? | **Yes No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Emotions/Sleep** |  | **Thyroid/Adrenals/Pituitary** |  |
| Insomnia - most of the night? | **1 2 3** | Feel cold or chilled easily | **1 2 3** |
| Do you have a hard time falling asleep? | **1 2 3** | I am chronically fatigued; a tiredness that is not usually relieved by sleep. | **1 2 3** |
| When you have a hard time falling asleep do you find it hard to stop thinking - turn off your brain? | **Yes No** | Outer third of your eyebrow is thinning or disappearing | **Yes No** |
| Do you get 6-8 hours of sleep? | **Yes No** | Feel slow-moving, sluggish | **1 2 3** |
| Anxiety, Fear or Nervousness? | **1 2 3** | Swelling in lower neck or “lump in throat” feeling when swallowing | **Yes No** |
| I often have to force myself in order to keep going. Everything is a chore. | **1 2 3** | Dizzy when rising or standing up from a kneeling position | **1 2 3** |
| Anger, Irritability, Aggressiveness? | **1 2 3** | Dark circles under your eyes? | **Yes No** |
| Are you currently taking antidepressants or anxiety meds? | **Yes No** | Course or thinning hair? | **Yes No** |
| **Immune** |  | Do you get hot flashes or night sweats? | **Yes No** |
| Do you get sinus infections on a yearly basis? | **Yes No** | I have experienced long periods of stress - my life is very stressful. | **Yes No** |
| Do you get the flu every year or two? | **Yes No** | Gag easily? | **Yes No** |
| Do you have asthma? | **Yes No** | Need coffee or some other stimulant for energy? | **Yes No** |
| Do you have an autoimmune disease? | **Yes No** | Muscles are weak or tremble. | **Yes No** |
| Did you get ear infections or strep throat as a child or now? | **Yes No** | Sensitive to noise or light? | **Yes No** |
| Have you used prednisone? | **Yes No** | Heat intolerance | **1 2 3** |
| Do you have frequent joint pain or swelling? | **Yes No** | Inward trembling | **1 2 3** |
| Do you get hives? | **Yes No** | Do you crave salt or salty food? | **Yes No** |
| Do you get bronchitis? | **Yes No** | Do you get swollen ankles? | **Yes No** |
| Were your tonsils removed? | **Yes No** | Have you gained weight around the waist?! | **Yes No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Heart/Kidney** |  | **Sugar Handling** |  |
| Have you ever had kidney stones? | **Yes No** | Get “shaky” if hungry | **1 2 3** |
| Have you had UTI’s | **Yes No** | “Lightheaded” if meals delayed | **1 2 3** |
| Do you experience “irregular or a fast heart beats on occasion? | **Yes No** | Tired after eating | **1 2 3** |
| Shortness of breath | **1 2 3** | Fatigue, eating relieves | **1 2 3** |
| Do you have high blood pressure? | **Yes No** | Crave bread or sweets | **1 2 3** |
| Nose bleeds | **1 2 3** | Frequent urination | **1 2 3** |
| Bruise easily? | **Yes No** | Always thirsty | **1 2 3** |
| High altitude discomfort | **1 2 3** | Can’t think, foggy brain relieved by eating | **1 2 3** |
| Hands and feet go to sleep easily. | **1 2 3** | **Musculoskeletal** |  |
| Toe or muscle cramps | **1 2 3** | Joint pain or stiffness | **1 2 3** |
| Noises in head or ringing ears | **1 2 3** | Stiff or sore feet when getting up in the morning | **1 2 3** |
| Dull pain or tension in chest | **1 2 3** | Osteoporosis/Osteopenia | **Yes No** |
| History of using margarine or vegetable oil. | **Yes No** | Leg or toe cramps | **1 2 3** |
| Eat fast food or at a restaurant more than 2 times a week. | **1 2 3** | Bone Spurs | **Yes No** |
| Do you eat 3-4 servings of vegetables and fruits every day. | **Yes No** | Swelling, inflammation, of knees or hands? | **Yes No** |
| How many times per week do you eat red meat? | **#** | Restless legs at night | **Yes No** |
| Do you drink pop/soda? How many per day? | **#** | Muscle weakness - shake easy with exertion | **Yes No** |
| Have you ever been anemic? | **Yes No** | Have you used a drug/shot for osteoporosis/osteopenia | **Yes No** |
| **Women Only:** |  | **Men Only:** |  |
| Excessive bleeding during menstruation? | **Yes No** | Urination difficult or dribbling? | **Yes No** |
| Painful breasts/breast tenderness? | **Yes No** | Frequent night urination? | **Yes No** |
| Premenstrual Tension? | **Yes No** | Diminished sex drive or ability? | **Yes No** |