Integrated Health Center
7286 S. Yosemite St. #150
Centennial, CO 80112

Cranial Electrotherapy Intake Form

Name _____ Date _____

If minor Child list Parent or Guardian Name_____

Address_____ Date of Birth_____

Telephones: Home_____ Work _____ Cell_____

Email address: _____

Person to Contact in Emergency _____ Phone _____

Relationship Status_____ Number of Children _____

Current Doctor _____ Therapist _____

Current Prescription Medications/Supplements_____

_____

Exercise_____ Diet_____

Daily Intake: Alcohol _____Cigarettes _____ Level of Stress in your life (1-10)_____

Reason for Visit_____

_____

Have you ever been diagnosed with Depression, Anxiety or Insomnia? If yes, when?_____

_____

Have you ever been treated for Depression, Anxiety or Insomnia? If yes when and what? _____

_____

Mark the following areas of disease or symptoms. Use C = current or P = past

Emotional / Psych	**Endocrine**	**Cardiovascular**
Depression	Adrenal	Angina
Eating Disorder	Pituitary	Stroke
Mood Swings	Hyperthyroid	Heart Attack
Substance Abuse	Hypothyroid	Hypertension
Anxiety	**Neurological**	**Respiratory**
Auto-Immune	Epilepsy	Bronchitis
Allergies	Dizziness	Emphysema
Cancer	Insomnia	Pneumonia
Fatigue	Migraines	Tuberculosis
Fever (severe)	**Muscular-Skeletal**	**Digestion**
Fibromyalgia	Arthritis	Constipation
Fungal Infections	Back Pain	Diabetes
Herpes	Carpal Tunnel	Diarrhea
Lyme Disease	Gout	Hepatitis
Mononucleosis	Skin Disorder	Hypoglycemia
Urinary	**Ear, Nose, Throat**	Jaundice
Bladder infection	Earache	Ulcer
Kidney Stones	Jaw Pain (TMJD)	Liver Disorder

AUTHORIZATION AND CONSENT FOR CRANIAL ELECTROTHERAPY TREATEMENTS

This authorization and consent form is an effort to make you better informed about Cranial Electrotherapy Treatments (CES). We encourage you to ask our staff any questions you may have. You are also encouraged to conduct your own research or consult with your own health care provider if you have additional questions. Cranial Micro-current is a non invasive, low level of current that activates specific groups of nerve cells that are located at the brainstem. These groups of nerve cells produce the chemicals serotonin and acetylcholine, which can affect the chemical activity of nerve cells in the nervous system. By changing the electrical and chemical activity of certain cells it amplifies activity in some neurological systems, and diminishes activity in others. This neurological fine tuning is called modulation, and occurs either as a result of, or together with the production of electrical activity patterns in the brain known as an alpha state. Such alpha rhythms are accompanied by feelings of calmness, relaxation and increased mental focus.

CES treats depression, anxiety and insomnia by passing tiny electrical currents similar to those found naturally in the body imperceptibly through the brain. The micro-current moves electrons through the brain at a variety of frequencies, collectively known as harmonic resonance. This normalizes the electrical activity of the brain as measured by an electroencephalogram (EEG). The patient undergoing CES treatment will often report a pleasant, relaxed feeling of well-being. Improvement is sometimes experienced during treatment, but may be seen hours later, or even the day after treatment. Depression control is generally experienced after three or more weeks of 8-10 treatments consecutively. Cranial electrotherapy is FDA approved for the treatment of Depression, Anxiety and Insomnia.

To Achieve Optimal Results: We recommend a series of a minimum of 8-10 micro-current treatments during a 2-4 week period as recommended by our licensed practitioners. Following the series of acute treatments, it is recommended to have 1 treatment per month in order to maintain optimal results.

Limitations and risks: Electrotherapy treatments cannot be performed on patients who have any of the following conditions: If a client is pregnant and/or has serious health conditions (Cancer, heart problems, etc.) or suffers from any of the following contra-indications: epilepsy, seizure, thrombosis or phlebitis, and all infectious illnesses. If a client has: cardiac pacemaker, metal implants anywhere in the face, or is using an anabolic steroid. In some clinical trials 1% of patients experienced headaches, nausea, dizziness and skin irritation.

Client Certification: I hereby certify I do not have any of the foregoing conditions, devices or implants ("Limitations"). Initials: _____

Waiver: I understand and acknowledge there are risks involved when using Electrotherapy treatments, including, but not limited to, those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive Integrated Health Center (IHC) or any of its staff if such results or complications that do occur. In consideration for IHC performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects or damages, which might occur to me while I am undergoing or after this procedure. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Integrated Health Center, LLC, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure. I agree this waiver and release shall bind the members of my family and any spouse or domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue.

Patient Name: _____

Patient or Guardian Signature:_____ Date:_____

Disclosure Statement and Consent Form

Integrated Counseling, LLC
7286 S Yosemite St. #150
Centennial, CO 80112
‘(303) 220-7319

We endeavor to integrate sound psychological and educational principles in your care. Please take the time to read this Disclosure Statement carefully, ask about any matters that seem unclear.
Counselor: Christina Szarka, M.S. Marriage, Family, and Child counseling
Colorado State University – M.S.
Credentials: Registered Professional Counselor - State of Colorado
Emergency Contact: (720) 341-3857
If you are experiencing a life-threatening emergency, call 911 or go to the nearest hospital emergency room and contact your counselor from there. A list of emergency contacts are on the next page.

Your Rights and Information

The Colorado State Department of Regulatory Agencies regulates the practice of licensed and registered mental health counselors. Any questions, concerns or complaints may be directed to: Colorado State Grievance Board 1560 Broadway, Suite 1340 Denver, CO 80202 or call 303-894-7766.
You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and fee structure.
You can seek a second opinion from another therapist and/or terminate therapy at any time.
In a professional relationship, sexual intimacy between a therapist and client is never appropriate and should be reported to the board to the State Grievance Board.
Generally speaking, information provided to and by the client during therapy sessions is legally confidential and cannot be released without the clients consent. There are exceptions to this confidentiality, some of which are listed below as required by law:

- Legal confidentiality does not apply in a criminal or delinquency proceeding, client-initiated court cases or grievance inquiries, providing information to insurance companies, supervision or consultation, grave disability, court order, or client’s authorization to release information. (Colorado statute 12-43-218, C.R.S. 1998)
- Mental health providers are required by law to report cases of any child neglect or physical/sexual abuse to county child protective services.
- Additionally, if any individual becomes dangerous to himself/ herself or others, or is incapable of caring for himself/herself, confidentiality will be broken in order to arrange for appropriate care.

Scheduling Policies
Standard cranial electrotherpay sessions are 20 minutes.
Please call our message center at 303-220-7319 to request or cancel an appointment.
Payment Policies: Please Read And Initial Each Item:
____1. Payment is due at the time of your counseling session.
____2. Fees are based on the fee schedule provided, which you will review with your counselor.
____3. The full session fee is charged for cancelled or missed appointments within 48 hours of appointment. (Clients receiving financial assistance are responsible for payment of cancelled/missed appointments.)
____4. Fees for auxiliary services are pro-rated at the regular hourly session fee. This includes (not limited to) written reports, insurance correspondence, court appearances and school meetings, as deemed necessary.
By signing below, I acknowledge I have read the preceding information, it has also been provided to me verbally, and I understand my rights as a client or as the clients responsible party, and agree to counseling under these conditions.

Printed Name of client(s)

_____

Signature of client(s) or Legal Guardian if client is a minor:

_____ Date _____