Consent to Receive Services

Savvy Holistic Woman
Abigail A. Thurston, L.M.T., C.L.P.
P.O. Box 4133 Clifton Park, NY 12065
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518.836.5084

About the services offered by Abigail A. Thurston, L.M.T., C.L.P.

Abigail A. Thurston, L.M.T., C.L.P. treats people, not disease, using several holistic modalities such as, but not limited to the following: acupressure, massage, color, sound, crystal healing, energy medicine, energy kinesiology, chakra balancing, 5 element theory and others as seen fit. Abigail locates the source of imbalances in the body and provides corrections using holistic modalities, which activate your own bodies healing mechanisms. Each session has the intention of harmonizing the energetic field between the conscious and subconscious mind by identifying core-limiting beliefs. The corrections coupled with your responsibilities of maintaining balance in the 5 Basics of: ***Food *Water *Rest *Exercise & *Owning your own power** to support your healing potential
.
As these 5 Basics are kept in balance it supports the holding of treatments provided, allowing the life force energy to flow freely through your body. Your body then has the ability to heal itself. The services I offer are considered energy balancing or healing. The services are not medical treatments and are not meant to diagnose treat or cure any symptom, stress or disease.

Consent to Receive Services from Abigail A. Thurston, L.M.T., C.L.P.

I, _____, understand that the treatments received from Abigail A. Thurston are not intended to substitute for professional medical or psychological advice; are not intended to diagnose, treat or cure any medical or psychological issue, condition, stress or symptom, nor do they replace treatment with my healthcare professional. I take 100% responsibility for my health and will promptly contact my professional healthcare provider in the event that I feel I have a medical or psychological issue. I fully assume the risk related to receiving a session with ANY or ALL of the holistic modalities including but not limited to the LifeLine Technique, Psych-k, Touch for Health, Total Body Modification, Emotional Freedom Technique, CranioSacral Therapy, or Massage used by Abigail A. Thurston. I hold Abigail A. Thurston harmless for any claims related to receiving harmonizing with ANY of the techniques used. I hold the creators, teachers and organizations that trained Abigail A. Thurston harmless from all claims related to receiving services or balances as well.

Print your name: _____
Signature: _____ Date: _____

Appointment and Fee Policies

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Long-Distance Appointments

I will call you at the designated appointment time. My phone may appear as Restricted on your caller ID. Please be prepared to focus on your appointment. A quiet environment, a charged phone being in an area of good phone reception will give you the most value during your appointment.

Payment and Fees

Please come to your appointment prepared to make payment for services rendered with cash or plastic. Checks are not accepted.

One Hour Appointment	$97
"Feel Happier" Package of 12, One Hour Appointments	$997

Gift Certificates

Gift Certificates are available for your friends and loved ones. Just ask!

Missed Appointments

Kindly provide 24 hours notice if you need to reschedule an appointment. If you are unable to do so, a fee of $20 for missed appointments will be billed to you. Please honor your appointment time by arriving on time. Late arrivals may reduce the amount of time for your appointment without reducing appointment fee.

I have read and agree to the above Appointment and Fee Policies for Heart in Hands.

Signature:_____ Date: _____

Confidential Health, Physical Activity, and Lifestyle History

Please print and answer all the questions to the best of your ability.
Bring to your appointment or email back to Abigail@SavvyHolisticWoman.com prior to your appointment.

General Information

How did you hear about Abigail A. Thurston, L.M.T., C.L.P.? _____
Name: _____ Date: _____
Age:_____ Date of Birth: _____
Street:_____ Town: _____
State:_____ Zip: _____
Home Phone Number: _____ Cell: _____ Work: _____
Email Address: _____
Emergency Contact
Person:_____Relationship:_____
ER Contacts phone number: _____ Cell: _____ Work: _____
Address: _____
Are you currently seeing a medical practitioner? _____
If so, what kind of practitioner(s), name(s) and phone number(s):
_____
_____
_____
Marital Status:
Single _____
Married _____ How Long? _____
Widowed _____ How Long? _____
Divorced _____How Long? _____
Do you want to/plan to marry (again)? _____
Number of children: _____ Boys (ages) _____ Girls (ages) _____
Is your mother living? _____ If not, date of death: _____
Is your father living? _____ If not, date of death: _____
Did your parents divorce? _____
If so, how old were you when they divorced? _____
Do you have siblings? _____ If so, how many, gender and ages: _____

What is your intention for your healing session(s)?
_____
_____

Lifestyle

Alcohol _____ How often _____ How much _____
Coffee _____ Decaf or Regular _____ Cups per day _____
Candy _____ Chocolate _____
Sugar _____ Sugar Substitute _____ Brand _____
Soda _____ Diet or Regular _____ How often/How much _____
Cigarettes _____# per day _____ Packs per week _____
TV Viewing _____ Hours per week _____
What type of programming do you watch? _____
Do you like to read? _____
What do you like to read? _____
Do you listen to music? _____
What kind of music do you listen to? _____

Do you consider yourself creative? _____
What is your favorite creative expression? _____
Do you keep a journal? _____
Do you have a specific spiritual practice? _____
Are you passionate about life? _____
If not, what would you like to feel more passionate about? _____
_____
Are you comfortable with your home environment? _____
Are you comfortable with your financial situation? _____
Are you happy with the relationships you have with your immediate family? _____
Are you happy with your employment? _____

If you knew you could not fail, what would you be doing differently? What would your life be like? _____
_____
_____
How would you describe your ability to express emotions such as happiness, anger, fear, sadness, grief etc.? Arethere emotions that are more difficult to express?
_____
_____
_____
What are your goals for your life?
_____
_____
_____

Health History

What are your goals for your health?
_____
_____
_____

List current medication(s) (prescribed or over the counter), vitamins, nutritional supplements that you take and the Dosage (number of pills/day).
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Describe your energy level:
_____
_____
On average how many hours per night do you sleep?
_____
Is your sleep disturbed at the same time each night, if so what time?
_____

Please describe an average day's intake of food below.

_____
_____
_____
_____
_____

How many times do you eat daily? _____
What sort of protein are you eating? _____
Do you drink water? _____ How many ounces daily? _____
Do you exercise? _____
What kind of exercise do you enjoy? _____
Number of days a week you exercise: _____

1) Accidents? 2) Injuries? 3) Surgeries?
Please describe and date your accident/injury/surgery and treatment you received:

_____
_____
_____
_____
_____
_____

Height: _____ Weight: _____

Current health concerns:
1) _____
2) _____
3) _____

Do you have any recurring symptoms?

_____

If so, please describe briefly.

If there is a time of day they most frequently occur please indicate and explain.

For the below health history please indicate: C – Current P- Past and Date and Location

Musculoskeletal System

Bone and joint issues _____
Tendonitis _____
Bursitis _____
Broke/Fractured Bones _____
Arthritis _____
Sprains/Strains _____
Pain in the Low Back, Hip or Leg _____
Pain in Neck, Shoulder or Arm _____
Headaches/Head Injuries _____
Jaw Pain _____
Lupus _____
OTHER_____

Circulatory System

Heart Condition _____
Varicose Veins _____
High or Low Blood Pressure _____
Blood Clots _____
Lymphedema _____
OTHER _____

Respiratory System

Breathing Difficulty _____
Sinus Problems _____
Allergies _____
OTHER _____

Skin
Allergies _____
Rashes _____
Athletes Foot _____
Warts _____
OTHER _____

Nervous System
Numbness/Tingling _____
Chronic Pain _____
Herpes/Shingles _____
Fatigue _____
OTHER _____

Digestive /Urinary System Reproductive
Constipation _____
Gas/Bloating _____
Diverticulitis _____
Irritable Bowel Syndrome _____
Kidney/Bladder problems _____
OTHER _____

Bloating _____
Cramps/Pain _____
Mood Swings _____
Breast Tenderness _____
OTHER _____

Menstrual Cycle
Painful Periods _____
Irregular Periods _____
Absent Periods _____
Pre- Menopausal/Menopausal _____
Pregnant?? _____
If so, how many weeks? _____
OTHER _____

Please check those that apply:
Dentures_____ Contacts _____ Transdermal Patches _____
IV Port _____ Breast Implants _____