wellness minneapolis

a fresh approach to health care

4450 Nicollet Ave S Minneapolis, MN 55419
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Complementary & Alternative Health Care Client Bill of Rights

1. Name of Unlicensed Complementary and Alternative Health Care Practitioner:
Lisa Leonard, 4450 Nicollet Ave. S., Minneapolis, MN 55419; lisa@wellnessmpls.com

2. Education Level of Practitioner: Your practitioner has an MA in Counseling and Psychological Services and has completed Healing Touch levels 1–4 (certification level HTP-A). Please see your practitioner's biographical information on www.wellnessmpls.com.

As of July 1, 2001, Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive, and acknowledge that you have received by your signature on the next page/back of this page, the following information prior to your treatment.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

3. Supervisor of Energy Work Therapists: Not applicable.

4. Complaints: If the Client has a complaint or concern about the care or services they have received, the Client may contact the supervisor in paragraph 3 above or the Office of Unlicensed Complementary and Alternative Health Care Practice located in Minnesota Department of Health: P.O. Box 64882, St. Paul, MN 55164-0882; (651) 201-3728; fax: (651) 201-3839; richard.hnasko@state.mn.us; www.health.state.mn.us

5. Fees: Payment is due in full at the time of service. Payment options include cash, check, or credit card (cash or check preferred). Energy work is a taxable service.

Please see your practitioner's page on the Wellness Minneapolis website for detailed pricing information.

Cancellation Policy: Wellness Minneapolis requires 24-hour notice for rescheduling or cancellations. Payment will be due in full for rescheduling or cancellations with less than 24-hour notice. Repeat offenses will require credit card payment in advance to hold appointments.

6. Change of Price: Clients have the right to reasonable notice of changes to the prices, services, or policies.

7. Theoretical Approach. Healing Touch is a biofield therapy in which practitioners consciously use light touch or near-body hand movements in a heart-centered and intentional way to clear and balance the human energy system to support and facilitate physical, emotional, mental, and spiritual health.

8. Right of Information: Clients have the right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

9. Right to Confidentiality: Client records are confidential and will not be released, unless authorized by the client in writing or as otherwise provided for by law.

10. Right to Self Access: Clients have the right to access to their own records maintained by the Practitioner's office, in accordance with state statute sections 144.291 to 144.298.

11. Personal Interaction: Clients have the right to expect courteous treatment, free from verbal, physical, or sexual abuse.

12. Other Treatment Available: Other energy-therapy services are available to the Client in this same community. These can be located by asking the Practitioner, asking the person/provider who referred you to this practitioner, or conducting an online search.

13. Right of Agency: The Client has the right to choose freely among available practitioners and to change practitioners after services have begun.

14. Records Transfer: The Client has the right to coordinated transfer of their records when there will be a change in the provider of services.

15. Right of Refusal: The Client may refuse services or treatment, unless otherwise provided by law.

16. Right of Nonretribution: The Client has the right to assert any and all of the above-mentioned rights without retaliation from the Practitioner.

I, _____, acknowledge by my signature that I have received and understand the Complementary and Alternative Health Care Client Bill of Rights.

Signature _____ Date _____

Thank you for taking the time to fill out this health history questionnaire. The information provided allows your practitioner to create the most effective and appropriate treatment possible. You may skip any questions you do not feel comfortable answering. All information you share is confidential.

GENERAL INFORMATION:

Name Date

Address Phone

Email

Emergency contact Relationship to you Phone

Date of birth Preferred gender pronouns (she/her, he/him, they/theirs, _____)

Education/Occupation

Living situation (partner/family/animal companions/solo; is home supportive? stressful? Social/personal support?)

Military service (branch and years)

HEALTH HISTORY and GOALS

Have you received energy therapy before? If so, what modality (Healing Touch, Reiki, pranic healing, etc.)?

Current overall health condition Health concerns (describe further on next page)

Current nutritional status Nutritional concerns (describe further on next page)

Last physical exam date

Current active healthcare professionals (physicians, chiropractors, nutritionists, bodyworkers, etc.)

Medical/health conditions (diagnoses and dates)

Hospitalizations/surgeries

Accidents/falls/physical injuries

Sleep quality/sleep-aid usage/average hours of sleep per night

Current prescription or over-the-counter medications

Supplement use (vitamins/minerals; herbs; homeopathy; flower essences; other)

Daily water intake

Use of recreational drugs/alcohol/caffeine/tobacco

Current self-care practices (movement, meditation, relaxation, body care, writing, hobbies, other interests)

Your perceived strengths

Spiritual beliefs/practices/affiliations

Is your belief a source of support to you? Word(s) or name(s) you use for a higher power

Using a scale of 1–10, with 1 being mild and 10 being extreme, please rate these **areas of concern.**

___Personal relationships
___Physical health
___Mental health
___Emotional health
___Spiritual
___Work
___Finances
___Eating/Nutrition
___Addiction
___Depression
___Mood swings
___Anger
___Anxiety
___Panic or anxiety attacks
___Trauma/PTSD (self or family)
___Memory problems
___Personal direction
___Headaches
___Pain
___Fatigue/lethargy
___Hormonal issues
___Allergies
___Sleeping issues
___Personal safety
___Major life change
___Other

Please briefly describe any items rated 7 or above.

What change would you like to see in yourself as a result of your session?

Is there anything else you wish to share, or any question you have about me or about energy work?

_____

I understand that the treatment given here is for general wellness purposes, and that although energy work often results in a marked reduction of unpleasant symptoms, no particular result is guaranteed. I understand that an energy-work therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand that I have the right to stop treatment at any time during the session.

Signature Date

_____ _____