Name: _____

Contact email: _____

Contact phone number: _____

Patient History Form

1. Are you on Active Duty or a Veteran?
2. Are you a first responder? (Law Enforcement, EMS, Firefighter)
3. Have you had a traumatic experience? Yes or No. (We do not require details of your traumatic experience to successfully treat you)
4. Which category of trauma best describes your traumatic experience?
   a) Combat or military related
   b) First responder related (EMS, Law Enforcement, Firefighter)
   c) Civilian trauma
   d) Childhood trauma
   e) Sexual assault related trauma
5. Are you under the care of a behavioral health professional?
6. Do you have a mental health diagnosis? Please name each diagnosis you have.
7. Are you on any medications that thin your blood? (e.g. anticoagulants such as aspirin, Coumadin, Eliquist or heparin)
8. Are you (or could you be) pregnant?
9. Do you have an intense and disabling fear of vomiting?
10. Do you have a diagnosis of traumatic brain injury (TBI)?
11. If you have a diagnosis of TBI is it:
    a) Mild TBI
    b) Moderate TBI
    c) Severe TBI
13. Do you have chronic lung disease?