Please fill this out as accurately as possible. It will help me plan the most efficient SHEN sessions for you.

Client's History & Reasons for Wanting SHEN

Name________________________ **Phones: Hm** ____________ **Wk** ____________

Address________________________ **City** ____________ **State/Pvnc** ____ **Zip** ________

I was referred by: ____________________, **a health professional** ❑ **a relative/friend** ❑ **I responded to an ad** ❑

Date of Birth: ____/____/____ **Occupation:** ______________ **Date form completed:** ____/____/____

(Please use back of each page if additional space is necessary)

1. *I wish to receive SHEN to help me with:*

a. ____

b. ____

c. ____

d. ____

2. *Please list the principle therapies, growth work, and bodywork you have had.*

a. ____________________ **b.** ____________________

c. ____________________ **d.** ____________________

e. ____________________ **f.** ____________________

3. *Please list the therapists, doctors or other health care professionals you currently see and the reason you are seeing them.*

a. ____________________ Reason ____________________

b. ____________________ Reason ____________________

c. ____________________ Reason ____________________

d. ____________________ Reason ____________________

4. *Please list all prescriptions you are currently taking and tell me what they are for.*

a. __________ for: __________ **b.** __________ for: __________

c. __________ for: __________ **d.** __________ for: __________

5. *Have you ever been given a prescription drug for:* Anxiety ❑ Depression ❑ Panic attacks ❑ Nervous breakdown ❑ Psychotic illness ❑ Sleep ❑ Please list the names of those prescription drugs you remember.

____

6. *Is/was anyone in your immediate family an alcohol or drug abuser?* Mother ❑ Father ❑ Sibling(s) ❑ Partner ❑ Child(ren) ❑

____

Please turn the page and continue

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7. *Have you ever been under the care of a psychologist or psychiatrist, been hospitalized or sent to a special treatment facility for any psychiatric reason?* Please indicate when, the reason(s) and the outcome.

8. *Have you ever been violent with or physically hurt members of your family or other people?* What were the circumstances?

9. *Please tell me about both your past and current use of alcohol and/or recreational drugs.*

10. *Describe your habits, behaviors, emotional patterns you think may be caused or affected by early life events.*

11. *Briefly describe the emotional traumas in or around your life that affected you the most. Include in utero, birth and infancy.*

12. *Please mention the emotional traumas in or around your life you remember but do not think have affected you.*

13. *Please list significant accidents, injuries, operations, or illnesses you have had. (Include any childbirth difficulties.)*

a. ____________ **f.** ____________

b. ____________ **g.** ____________

c. ____________ **h.** ____________

d. ____________ **i.** ____________

e. ____________ **j.** ____________

Please go on to the next page

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14. Please check the appropriate columns.

Physio-emotional Conditions	Have had	Now having	Never had
a. Frequent aches/pains in my _________			
b. Physical abuse (known or suspected)			
c. Emotional abuse (known or suspected)			
d. Sexual abuse (known or suspected)			
e. Jaw problems and/or tooth grinding			
f. Migraines			
g. Tension headaches			
h. Suicidal feelings			
i. Suicide attempts			
j. Panic attacks or phobias			
k. Asthma			
l. Depression			
m. Insomnia or other sleep problems			
n. Nightmares or recurrent dreams			
o. Death of a loved one			
p. Divorce of self, parents or children,			
q. Loss of home or job			
r. Prolonged or unexpressed grief			
s. Low back pain			
t. Compulsive eating, talking, spending, cleaning etc.			
u. Excessive worries about health			
v. Nervous breakdowns			
w. Eating disorders			
x. Digestive or bowel problems			
y. Chronic fatigue			
z. Sexual dysfunction			
aa. Pre/Menstrual or Menopausal Difficulty			
bb. Birth trauma			
cc. Undiagnosed physical or other symptoms			
dd. Other problems			

15. Please rate your experience of emotions.

Emotion	Often	Occasionally	Never
Sadness			
Anger			
Fear			
Grief			
Rage			
Joy			
Anxiety			
Sexual Feelings			
Confidence			
Embarrassment			
Peace			
Righteousness			
Guilt			
Excitement			
Irritation			
Shame			
Love			
Terror			
Inadequacy			

16. Please evaluate yourself as follows:

1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent

Category	1	2	3	4	5
Health					
Self esteem					
Well-being					
Sexual enjoyment					
Ability to handle stress					
Expressing emotions					
Feeling your emotions					
Freedom from pain					
Enjoyment of life					

17. *Do you have close friends, family members, a partner, psychotherapist or counselor who will help support you if you go through a difficult period during your emotional unfolding*? **Yes** ❑ **No** ❑

18. *Do they understand that experiencing buried emotional pain is often necessary to complete and release it and move on?* **Yes** ❑ **No** ❑

*I represent that this information is complete and accurate to the best of my memory. Signed*_____________________________ *Date*_________

I am the legal guardian of the client described above and agree to this disclosure and to him/her receiving SHEN

*Signed*__________________________________ *Date*____________

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SHEN Client's Statement of Purpose & Responsibility

1. Russell Fox, CST/CSI, my SHEN® Provider, has explained to me that the purpose of SHEN is to improve my emotional health by relaxing portions of my body in such a way that deeply held debilitating emotions can be released, so that the deeper, naturally occurring emotions of confidence, love and joy can be re-activated, experienced and utilized.
2. I understand that SHEN is not medical or psychiatric treatment, psychotherapy, analysis or counselling. My SHEN Provider has not offered, nor have I asked for, SHEN to be used as a substitute for any of these purposes.
3. I have asked for SHEN solely to improve my emotional health, help me relax better, deal with stress better, experience my emotions better and/or have a richer, fuller experience of life. I understand that while lifting my emotions to the surface may beneficially affect my physical and/or psychological health, my behavior and attitudes, I have not asked for, nor am I receiving, SHEN as treatment for any specific medical or psychological condition.
4. I have been advised that if I am being treated for any emotionally related disorder(s) by a physician, or am in therapy for any reason, that I should notify my physician or therapist that I am receiving SHEN. I have also been advised to inform my physician or therapist that SHEN may lift to the surface emotions that are related to the disorders or conditions for which my physician may be treating me, or for which I am in therapy.
5. I have been given printed explanations about the nature of SHEN and its results to give to my medical doctors or other health care professionals I am seeing as a patient or client.
6. I understand that if any emotions are released from my body I will feel them and that this experience may include various bodily sensations as well as emotionally filled thoughts. I understand that some of these emotions may be unpleasant (such as fear, grief or shame) but that any unpleasant experiences will be temporary in nature. I am aware that the release and experience of these emotions may continue for some hours after my SHEN session.
7. I further understand that SHEN does not, and cannot, create new emotions and that any and all emotions I may experience are my own, previously buried emotions rising to the surface. I hold myself responsible for any and all emotions that I may experience during the course of, or as a result of, my SHEN sessions and for any actions I may take that may be influenced by those emotions. I specifically hold my SHEN Provider blameless for any actions I may take and/or behaviors that I may exhibit as a result of my emotions.
8. I understand that SHEN is a form of biofield therapeutics, or energy-work, and that my provider's hands will be placed on or near my clothed body throughout most of my sessions.

I affirm that I have read and understand all the above numbered items, and that my SHEN Provider has answered all the questions I have asked to my satisfaction.

*Signed*____ *Date*_________________

I am the legal guardian of the above client and agree to the above conditions in his/her behalf.

Signed ____ *Date* _________________

Russell Fox, CST/CSI
520-666-5251 Ph / 928-496-2111 Fax
SHENTherapyNow@gmail.com

The SHEN Wellness Center of Sedona
Biofield Therapeutics for Physio-Emotional Recovery
www.SHENTherapyNow.com

Dear ______________________________ Date ___________________

We share a client, _________________________________, who is receiving, or intends to receive, a series of SHEN® Physio-Emotional Release Therapy sessions from me. It is possible that the SHEN sessions may have a bearing on your therapeutic efforts and I would like to coordinate our efforts, if you would be interested. SHEN has been a useful adjunct to psychiatric and medical treatment and/or psychotherapy. I do not intend or offer SHEN Therapy as a replacement for them.

SHEN is a somatic therapy that frequently brings to the surface, discharges and completes bodily-held painful, debilitating emotions of fear, shame and anger. Completion of these emotions allows re-establishment or improvement of emotions and feeling states of confidence and well being.

Possible Expectations: SHEN often elevates dreams to a higher state of awareness and clients often exhibit increased and/or altered affect. Frequently this change of affect has been associated with improvement in a number of somatoform, psychosomatic or behavioral disorders. Distinct improvements are noted with visceral neuroses, migraines, premenstrual and menstrual distress, psychogenic sexual dysfunction and other emotionally driven disorders. In addition, re-connecting with feelings of self confidence not felt since deeply traumatic events has proven generally beneficial for many.

I will not knowingly perform SHEN on anyone diagnosed as having suicidal tendencies or who has tendencies towards dangerous, impulsive acts, except under the direction of an appropriately licensed health professional. If you have any concerns about these issues, or feel that a process such as SHEN might be contra-indicated in any way, I would appreciate your contacting me before I proceed further.

Signed: ____

CONSULTATION CONSENT FORM

I hereby authorize my SHEN Provider, ____,

and ____,

my physician(s) and/or therapist(s), to consult and exchange any information regarding the progress, course and results of my SHEN sessions that they may feel useful for me.

I am the legal guardian of _________________________ and execute this consent for her/him.

Signed_________________________________ Date______________