

For office use only	
Reg.#	_____
Date received	_____

Gate Location \_\_\_\_\_ Date \_\_\_\_\_

## **2011 Transformational Gate & Eurogate Practitioner's Form**

(Please Print)

Practice Member's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Practitioner's Name \_\_\_\_\_ Length of time in care \_\_\_\_\_

If graded with Level of Care; Practice member has achieved

Most commonly:                    Level-1   a   b   c    Level-2   a   b   c    ADVANCED Care   a   b   c

Currently responding at:        Level-1   a   b   c    Level-2   a   b   c    ADVANCED Care   a   b   c

**Practice member has attended a gate within the past 2 years, please use the care information I provided on the Practitioner's Form from their last program. I am including only new spinal gateways and updates on this form.**

Please list Spinal Gateways for contact if known: (List R or L for right or left next to the area contacted. For example, if C1/2 is contacted on the right, place an "R" next to C1, and list as R C1/C2)

**Dominant Occiput:**    R    L

_____ OCC/C1 _____	_____ C1/C2 _____	_____ C2/C3 _____	_____ C3/C4 _____
_____ C4/C5 _____	_____ C5/C6 _____	_____ C6/C7 _____	_____ C7/T1 _____
S1 _____    S2 _____	S3 _____    S4 _____	S5 _____    CX _____	

**Out of Phase Spinal Gateways** \_\_\_\_\_

How would you grade this person's awareness of their spine/body/SRI position?

0 - No noticeable awareness      1 - Mildly aware      2 - Moderately aware      3 - Highly aware

	Structure	Breath	Wave	Energy	Oscillation
Cervical Spine:	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Thoracic Spine:	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Lumbar Spine:	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Pelvis:	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3

SRI:	Movement	Breath	Staying Present	
Position 1:	0 1 2 3	0 1 2 3	0 1 2 3	<input type="checkbox"/> Regularly practices SRI in office
Position 2:	0 1 2 3	0 1 2 3	0 1 2 3	<input type="checkbox"/> Regularly practice SRI on own
Position 3:	0 1 2 3	0 1 2 3	0 1 2 3	<input type="checkbox"/> Does not regularly practice SRI

Are there any areas that need special care or restrictions with regards to care? Are there any phases or Levels of Care that this practice member has, or has had difficulty progressing through? \_\_\_\_\_

	Moderate	High	Where?
Passive system tension (vert. / lig. / discs)	_____	_____	_____
Active system tension (spinal muscles and tendons)	_____	_____	_____
Neural Control system (adverse mechanical cord tension)	_____	_____	_____

Are there any questions about any part of this practice member's care that you want opinions on? \_\_\_\_\_

Is there anything you want the staff to know about this practice member that you have not mentioned above? \_\_\_\_\_

I, the referring practitioner, recommend this practice member to attend the Transformational Gate.

\_\_\_\_\_  
(Please print practice member's name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner's Signature