

For office use only	
Reg.#	_____
Date received	_____

Gate Location _____ Date _____

2012 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? _____

Where?

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

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