Laraine A. Tanzer, LCSW
License No. LCS23007
4540 Campus Drive; Suite 122
Newport Beach, CA. 92663
Tel. (949) 903-1823 Fax (949) 720-9808
Email: l.tanzer@sbcglobal.net Website: www.lainetanzer.com

PATIENT CONSENT FOR INTEGRATED EMDR (IEMDR)

I, _____, give my permission to my

psychotherapist, Laraine Tanzer, LCSW; to perform Integrated EMDR (IEMDR) to help me with my headaches. I understand that this is a new approach to treating headaches. IEMDR has had limited clinical and research validation. My therapist has explained to me that during the application of this procedure that disturbing past or suppressed memories, emotional or physical sensations may surface. My psychotherapist, Laraine Tanzer, LCSW; has reassured me that if I bring these memories, emotions or sensations to her attention during a treatment session that she can help me address them._____(initial)

I understand that IEMDR is to be used for *primary* headaches. IEMDR may not be used for headaches that are *secondary to medical conditions* such as, but not limited to, concussions, tumors, aneurysms, strokes, infections, diabetes, insulin-related disorders, cardiovascular diseases, hypertension, inflamed or clogged arteries, head injury, lupus, meningitis, arthritis, gout, or other inflammatory diseases, medication side effects, osteoporosis, gallstones, cancer or any other disease or disorder where the cause of the headache is essentially medical (organic) in nature. Since my medical evaluations have not revealed any of the above problems I give my permission to proceed with IEMDR._____(initial)

My psychotherapist, Laraine Tanzer, LCSW; has informed me that IEMDR involves touching specific places on my head and/or body. I give full permission for my therapist to touch me in the specified areas during my IEMDR treatment sessions._____(initial)

I have read and understood all of the above. I give my Laraine Tanzer, LCSW; permission to use IEMDR to treat my headaches._____(initial)

Signature:_____Date:_____