

Client Intake Form (Confidential)

Name: _____ Date: _____

Address: _____

Postcode: _____ City: _____

Place of Birth: _____ Time of Birth: _____ Date of Birth: _____

Phone: _____ E-mail: _____ Ins.: _____

☐ Female ☐ Male ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Please check if you have or have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> PARKINSON'S DISEASE |
| <input type="checkbox"/> ALLERGY SHOTS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> PINCHED NERVE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOITER | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> GOUT | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PROSTATE PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HERNIA | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HERNIATED DISC | <input type="checkbox"/> RHEUMATOID FEVER |
| <input type="checkbox"/> BREAST LUMPS | <input type="checkbox"/> HERPES | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BULIMA | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> MEASLES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> MIGRAINE HEADACHES | <input type="checkbox"/> TUMOR GROWTHS |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> _____ |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> _____ |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> _____ |

Family History: Please indicate if any family members have had any of the following medical problems and if so who:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Hepatitis/Liver Disease _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Alcohol Problems _____ | <input type="checkbox"/> Congenital Problems _____ |
| <input type="checkbox"/> Mental/Emotional Problems _____ | <input type="checkbox"/> Other _____ |

Describe any concerns and your objectives in seeking wellness services here:

I understand that the attending practitioners are not allopathic doctors (MDs) and do not portray themselves to be but are providing biofeedback and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioners do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, they do not diagnose, treat or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending practitioners' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do biofeedback testing, wellness consultation and other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

Signature of Client_____
Date