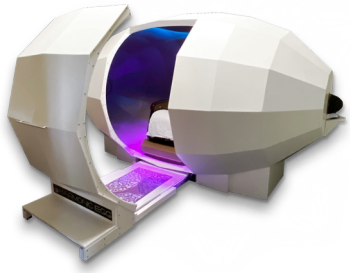

CONFIDENTIAL CLIENT APPLICATION

Client:_____ DOB:_____ Height:_____ Weight:_____

Telephone Home: _____ Work:_____ Cell:_____

Address:_____ Email:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Relationship Status: Single Married Partner Separated Divorced Widow Widower

Spouse/Partner Name:_____ # of children_____

Occupation:_____ Do you enjoy your job? Y N

Primary Reason for seeing us:_____

Have others helped you with the problem:_____

What are your expectations after the sessions:_____

Who can we **thank** for your being here (who referred you): _____

Check conditions listed below which you have experienced: Use P for over a year ago, C for current

METABOLISM
__Weight Gain
__Weight Loss
__High/Low BP
__Blood sugar
__Thyroid

SKIN
__Rash
__Eczema
__Dry Skin
__Acne
__Recent Botox
__Any recent substance Injection under skin

EYES/EARS/MOUTH
__Headaches
__Dizziness
__Ringing in Ears
__Blurred Vision
__Sinus Problems
__Difficulty Swallowing
__Mouth Sores

DENTAL
__Tooth Problems
__Root Canals
__Amalgam Fillings
__Difficulty chewing
__TMJ

CHEST
__Chest Pain
__Palpitations
__Cough
__Shortness of Breath
__Asthma

NEUROLOGIC
__Numbness or Tingling
__Weakness
__Insomnia
__Poor Balance

MALE
__ Prostate
__ Cancer

DIGESTION
__Heartburn
__Abdominal Pain
__Gas/Bloating
__Diarrhea
__Constipation
__Blood in stool
__History of Ulcers
__Colitis
__Liver Disease

URINARY
__Frequent Urination
__Difficulty starting Urination
__Urinary Incontinence

ALLERGIES
__Medications
__Chemicals
__Foods
__Plants

FEMALE
__Pregnant
__Problems with periods
__Cancer
__Breast Tenderness
__Breast Implants
__Menopausal Symptoms

STRUCTURAL
__Arthritis
__Bursitis
__Osteoporosis
__Foot/Ankle Swelling
__Blood Clots/Phlebitis
__Varicose Veins
__Recent Surgery
__Neck Pain/Problems
__Back Pain/Problems
__Sciatica

IMMUNE
__Chronic Fatigue
__Fibromyalgia
__Yeast Infections
__ Past viral infections
__ Past Strep or Mono
__ Epstein- Barr
__ Lyme

Medications, Herbs, Supplements (list name, dose, and purpose)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

We recommend drinking 90 - 128 ounces of water daily starting on the day before your first session and for the days of integration.
Do you expect any difficulty with this? Y N
Explain:_____

How much do you use? Alcohol_____ Tobacco _____

Coffee/Tea _____ Drugs/Marijuana_____

Injuries/Accidents? Y N When & Describe_____

Traumatic life events leading to any illness:_____

_____

Toxic Exposures:_____

Describe other medical conditions that we should be aware of:_____

__Cancer __Heart Problems __Stroke ___Seizures __Diabetes __MS

Other:_____

Areas in body of complaint or tension:_____

_____

Surgeries with dates (include location of metal plates/rods/screws)_____

_____

Family medical history: __Diabetes __Heart Problems __High BP __Cancer __Alzheimer's

Other:_____

Current Pain Level (1=very low, 5=very high): 1 2 3 4 5 Explain:_____

Current Stress Level (1=very low, 5=very high): 1 2 3 4 5 Explain:_____

Current Energy Level (1=very low, 5=very high) 1 2 3 4 5 Explain:_____

Describe any specific medical attention or assistance you will need while visiting our center (you must be able to get into the unit or bring a caregiver to help you)._____

_____

Will you be bringing a caregiver, nurse or spouse with you?_____

Please circle the word that best describes your current state of health:

Excellent Good Average Improving Declining Serious Debilitated

What brings you joy?_____

_____

Please circle the most emotional draining relationship or relationships in your life:

Significant Other Job Children Your Relationship with Yourself State of the World

Is your home environment peaceful or stressful most of the time?_____

Do you have trouble concentrating, or 'brain fog'? Y N Do you feel supported? Y N

What drives you, inspires you, gives you a sense of purpose:_____

_____

Please check the emotions that best reflect how you feel most of the time:

__Joy	__Sad	__Excited	__Optimistic
__ Anger	__Depressed	__Passionate	__Terrified
__Resentment	__Hopeless	__Safe	__Anxious
__Peaceful	__Despair	__Calm	__Alone
__Happy	__Blissful	__Afraid	__Frustrated

Do you adhere to any particular diet?_____

How many hours of sleep do you get on average? _____

Do you drink filtered or purified water? Y N

Describe your exercise/activity routine:_____

Are you sensitive to light / loud noise? Y N If Yes, please explain_____

Are you in fear regarding your health?_____

Regaining well being requires a strong personal commitment. How ready are you to make the lifestyle changes, the diet changes and the attitude changes that may be necessary to good health?

Ready Somewhat Not looking to make changes

I have read the above information and have filled out the form to the best of my knowledge. I understand that the questions on this form are being asked in order to better access my current circumstances and their relationship to my well-being. I further understand that I am voluntarily agreeing to have a relaxation therapy session and that no medical claims or promises of healing have been given.

Signature:_____ Date:_____