Client Intake Form
(Confidential)

Name:_____ **Date:**_____

Driver's Lic.#_____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Place of Birth: _____

Home Phone #:_____Work Phone #:_____

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

Occupation_____ Employer_____

Work Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse_____ DOB _____

Children's Names Birth Dates:

_____ _____

_____ _____

_____ _____

Person to contact in case of an emergency:_____

Home Phone #_____ Work Phone #_____

SOC INDEX:

Number of organs removed		Personal stress (1-10)	
Number of synthetic drugs used currently		No. of sugar type products in a day (1-10)	
Number of times you smoke in a day		Number of exercise sessions in a week	
Number of steroid type drugs used in the past year		Number of alcoholic drinks in a day (avg.)	
Number of amalgam (silver) fillings in your mouth		Number of caffeine products per day (coffee, tea, soda)	
Number of street drugs used each month		Number of toxic exposures (radiation, chemicals, insecticides, etc.)	
Number of all known allergies		Number of major injuries in the past	
Number of unresolved emotional factors(anger, depression, anxiety, etc.)		Number of major infections in the past	
I am responsible for my body 1-10		Number of glasses of water per day	
Amount of fat in diet 1-10		How many pounds overweight	

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

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

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

- ☐ Diabetes_____
- ☐ Hypertention_____
- ☐ Stroke_____
- ☐ Alcohol Problems_____
- ☐ Mental/Emotional Problems_____
- ☐ Heart Disease_____
- ☐ Hepatitis/Liver Disease_____
- ☐ Cancer _____
- ☐ Congenital Problems_____
- ☐ 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, we 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, excercising 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