

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 relationship 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:

<input type="checkbox"/> Joy	<input type="checkbox"/> Sad	<input type="checkbox"/> Excited	<input type="checkbox"/> Optimistic
<input type="checkbox"/> Anger	<input type="checkbox"/> Depressed	<input type="checkbox"/> Passionate	<input type="checkbox"/> Terrified
<input type="checkbox"/> Resentment	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Safe	<input type="checkbox"/> Anxious
<input type="checkbox"/> Peaceful	<input type="checkbox"/> Despair	<input type="checkbox"/> Calm	<input type="checkbox"/> Alone
<input type="checkbox"/> Happy	<input type="checkbox"/> Blissful	<input type="checkbox"/> Afraid	<input type="checkbox"/> 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: \_\_\_\_\_