Client's Name	**Initial testing and treatments are $195.00 and take approximately 1.5 hours. . All follow ups are $150**	
Address	Fax:	Any Inherited Diseases in your family? Yes No
City & Postal Code:	**E-mail:**	
Home Phone	Occupation	
Date of Birth Time of Birth	Place of Birth On a scale of 1 - 10 How much negativity do you have?	
List of Current Medications, Prescriptions & Supplements:		

Main Complaint	Secondary Complaint	Other Concerns
Sleep: Trouble falling asleep? Wakes during sleep? How many times a night?	Bowels: one a day two a day three or more a day	Digestion: Constipation? Diarrhea? Stomach Pain? Gas? Bloating? Acid Reflux? Heartburn? Other?

SOC This needs to be filled in with **"numbers"** not words. The more accurate you are the better the testing.

1. Number of organs &/or teeth have you had removed		11. What is your personal stress level on a scale of 1 - 10 (10 being high)	
2. Number of Prescription Medications that you are currently taking or recently taken		12. How many sugar products a day do you have (sugar in tea/coffee, cookies, pop etc)	
3. Number of cigarettes smoked per day		13. How many exercise sessions per week of 20 min. or more do you get (don't count working)	

4. Steroid drugs (sprays, inhalers or creams) used in the last year		14. Alcohol consumption per day on average	
5. Number of silver dental fillings, root canals, posts, crowns, false teeth, gold or any metals		15. Coffee/tea/caffeine/ chocolate per day do you have on average	
6. Number of Over The Counter drugs or street drugs used in the past few years		16. Xrays/flying/insecticides/chemical exposures/dental xrays/etc in the past year	
7. Number of allergies: food, drug or environmental		17. Major injuries in your **entire life**. Surgeries, car accidents, concussions, broken bones, any ER visit!	
8. Unresolved emotional issues over your life time (family, grief, work, emotional etc)		18. How many times in your **entire life** have you been on antibiotics (IV, caps, tabs, injections)	
9. How responsible are you for your own health on a scale of 1 - 10		19. How many glasses of water or natural fruit juice per day do you have	
10. How much fat is in your diet 2= ideal 4= average 5 = more		20. How many pounds overweight do you feel like you are?	

This is to acknowledge that I have been informed about the treatment being offered and I fully understand and accept that this treatment is being performed by a Internationally Licensed Biofeedback Technician.

1. I also agree to this information being stored and used only with consent of the client. **There are no print outs for this test.**
2. I understand that the information that I have given will reflect the accuracy of the testing involved.
3. I also understand that this treatment in NO WAY replaces conventional medicine and that I will inform my family doctor that I am receiving treatments. I also have been told that the therapy may help my problem; but will not offer a CURE. I accept the treatment offered having fully understood the above. I also understand that the therapist performing this treatment is not a medical doctor, **nor is she diagnosing, prescribing or replacing my family doctor.**

Signed: _____ Date: _____