**CONFIDENTIAL CLIENT APPLICATION**

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_ Weight:\_\_\_\_\_\_

Telephone Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 DENTAL DIGESTION FEMALE

\_\_Weight Gain \_\_Tooth Problems \_\_Heartburn \_\_Pregnant

\_\_Weight Loss \_\_Root Canals \_\_Abdominal Pain \_\_Problems w/periods

\_\_High/Low BP \_\_Amalgam Fillings \_\_Gas/Bloating \_\_Cancer

\_\_Blood sugar \_\_Difficulty chewing \_\_Diarrhea \_\_Breast Tenderness

\_\_Thyroid \_\_TMJ \_\_Constipation \_\_Breast Implants

 \_\_Blood in stool \_\_Menopausal

 \_\_Colitis

NEUROLOGIC MALE \_\_Liver Disease

\_\_Numbness or Tingling \_\_Prostate

\_\_Weakness \_\_Cancer

\_\_Insomnia

\_\_Poor Balance

SKIN CHEST URINARY STRUCTURAL

\_\_History of Ulcers

\_\_Rash \_\_Chest Pain \_\_ Frequent Urination \_\_Arthritis

\_\_Eczema \_\_Palpitations \_\_ Urinary Incontinence \_\_Bursitis

\_\_Dry Skin \_\_Cough \_\_Difficulty starting urine \_\_Osteoporosis

\_\_Acne \_\_Shortness of Breath \_\_Osteoporosis

\_\_Recent Botox \_\_Asthma \_\_Foot/Ankle Swelling

\_\_Any recent \_\_Blood Clots

 Injection under skin \_\_Varicose Veins

 \_\_Recent Surgery

 \_\_Neck Pain/Problems

 \_\_Back Pain/Problems

 \_\_Sciatica

EYES/EARS/MOUTH ALLERGIES IMMUNE

\_\_Headaches \_\_Medications \_\_Chronic Fatigue

\_\_Dizziness \_\_ Chemicals \_\_Fibromyalgia

\_\_Ringing in Ears \_\_Foods \_\_Yeast Infections

\_\_Blurred Vision \_\_Plants \_\_ Past viral infections

\_\_Sinus Problems \_\_ Past Strep or Mono

\_\_Difficulty Swallowing \_\_ Epstein- Barr

\_\_Mouth Sores \_\_ Lyme

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:

\_\_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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_