CLIENT:
DATE:

CLIENT INFORMATION

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.
PLEASE USE THE REVERSE SIDE IF NECESSARY WHEN COMPLETING THE REQUESTED INFORMATION.

NAME ______________________________
ADDRESS ______________________________
CITY ______________________ STATE ____________ ZIP ____________
HOME PHONE ______________________ BUS. PHONE ______________________
DOB ______________________ EMAIL ______________________
REFERRED BY ______________________

WHAT PROMPTED TODAY'S VISIT?

DO YOU HAVE EXPERIENCE WITH THE FOLLOWING?

HOMEOPATHY
ELECTRO ACUPUNCTURE
BIOFEEDBACK
HERBAL REMEDIES
OTHER (PLEASE EXPLAIN)

DO YOU REGULARLY USE THE FOLLOWING? IF SO, HOW MANY TIMES PER WEEK?

WHITE SUGAR
ALCOHOL
REGULAR COFFEE
DECAF COFFEE
TOBACCO
SODAS
WHITE FLOUR
NUTRASWEET

BRIEFLY DESCRIBE YOUR DIET

LIST ALL DENTAL SURGERIES & PROCEDURES; ROOT CANALS, CROWNS, MATERIALS USED ETC.
PLEASE INDICATE THE YEAR OF TREATMENT.

1. ______________________ Yr ________
2. ______________________ Yr ________
3. ______________________ Yr ________
4. ______________________ Yr ________

DATE OF LAST DENTAL VISIT ______________________
PURPOSE OF VISIT

CLIENT:
DATE:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR DIAGNOSED ILLNESS:
PLEASE LIST THE ILLNESS.

LIST SURGERIES, INJURIES, AND ACCIDENTS. PLEASE INDICATE THE YEAR OF TREATMENT:

1.____________________ Yr ______ 2. ____________________ Yr______
3.____________________ Yr ______ 4. ____________________ Yr______

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING REMOVED:
TONSILS REMOVED, Yr ________
ADENOIDS REMOVED, Yr ________
APPENDIX REMOVED, Yr ________

LIST ALL THE SUPPLEMENTS YOU ARE CURRENTLY TAKING:

WHAT IS YOUR MOST IMPORTANT HEALTH GOAL?

RATE YOUR **OVERALL** ENERGY LEVEL	LOW	MED	HIGH	VERY HIGH
RATE YOUR ENERGY LEVEL IN THE MORNING	LOW	MED	HIGH	VERY HIGH
RATE YOUR ENERGY LEVEL IN THE AFTERNOON	LOW	MED	HIGH	VERY HIGH
RATE YOUR ENERGY LEVEL IN THE EVENINGS	LOW	MED	HIGH	VERY HIGH

RATE YOUR GENERAL HEALTH:

VERY POOR POOR GOOD GREAT EXCELLENT

WHAT IS YOUR ACTIVITY LEVEL?

EXERCISE	1-3 x per week LIGHT (10-15min)	3-5 x per week MODERATE (15-30min)	5-7 x per week AGRESSIVE (40-80min)
AEROBICS Y N	LIGHT (10-15min)	MODERATE (15-30min)	AGRESSIVE (40-80min)
WEIGHTS Y N	LIGHT	MEDIUM	HEAVY

RATE YOUR INTEREST IN WELLNESS:

NEWBIE SOME INTEREST GROWING INTEREST VERY INTERESTED WANT TO KNOW MORE

HOW MOTIVATED ARE YOU IN BEING WILLING TO MAKE THE CHANGES NECESSARY TO INCREASE YOUR OVERALL WELLNESS?

NOT VERY MOTIVATED SOMEWHAT MOTIVATED VERY INTERESTED EXTREMELY MOTIVATED

CLIENT:
DATE:

WHAT ***SHOULD YOU DO*** THAT YOU KNOW YOU DON'T DO, WHEN IT COMES TO YOUR HEALTH?

WHAT DO YOU HAVE ***THE MOST TROUBLE CHANGING*** IN YOUR HEALTH HABITS?

Wellness Evaluation Authorization and Release Form

Electro-acupuncture and stress testing provide an opportunity to measure electrical responses and meridian flows of the body. Bioenergetic evaluation of the energy flow helps identify various stressors that might impede the electrical process. The evaluation may include recommendations for natural remedies, stress reduction methods, and/or nutritional changes designed to balance the energy meridians and enhance overall wellness. These recommendations are not cures for any known diseases, nor have they been proven clinically to eliminate any specific disease process. The bioenergetic evaluation is not a method of diagnosing, nor are the suggested remedies designed to replace any of the medications or treatments currently being provided or recommended by a primary care practitioner.

1. I fully understand that the attending consultant is not an allopathic doctor (MD) and does not pretend to be, but is a Bioenergetic Practitioner providing services that are not allopathic, but that is within the parameters of a natural health and wellness philosophy.
2. I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants, or radiation therapy, but is providing information and natural products to restore natural balance and optimum conditions for health and wellness based on the scope of his/her practice.
3. I fully understand that the consultant is not diagnosing or treating any illness or disease, but is only measuring the bioenergetic balance and overall stress responses of the body. and that these services may not be generally accepted and/or recommended by allopathic physicians or other health professionals.
4. I fully understand that the attending consultant is in no way encouraging me to terminate or modify any previous or ongoing therapies under the direction of any licensed practitioner and that the attending consultant can/will not dissuade me from seeking allopathic attention, recommendations, or modes of therapy from a licensed practitioner.
5. I presently seek consultation, advice, opinions, and/or programs. tests, evaluations, and/or products within the scope of the attending consultant's wellness practice based upon the principles of bioenergetic health and have solicited the attending consultant's services in good faith, exerting 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.
6. If I am accompanied by a minor or an incompetent. I give full faith that I am legally and totally responsible for them.
7. I authorize the attending consultant to provide his/her services to me on my behalf, and herby release him/her from any and all claims and potential claims arising out of my actions or failure to act upon his/her advice.
8. I give full faith that I have read and understand this document entirely, that I have received a verbal explanation of the same from the attending consultant, and that he/she has answered satisfactorily all of my questions regarding this form.
9. I am willing to declare and repeat under oath all of the above statements by request of the attending consultant.

I hereby consent to and authorize the above-described evaluation and consultation.

Client Signature: **Date:**

Parent or Guardian signature if under 18.