Wellness • Balance • Harmony

CONFIDENTIAL CLIENT APPLICATION

Client: _____ DOB: _____ Height: _____ Weight: ____lbs

Telephone Home: _____ Work: _____ Mobile: _____

Address: _____ Email: _____

City: _____ Province: _____ Postal Code: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Relationship Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widow ☐ Widower

Spouse Partner Name: _____ Number 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. Use 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

ALLERGIES
- ☐ Medications
- ☐ Chemicals
- ☐ Foods
- ☐ Plants

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

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

MALE
- ☐ Prostate
- ☐ Cancer

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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 select 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 in your life:

◉ **Significant Other** ○ **Job** ○ **Children** ○ **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: _____

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