CLIENT INTAKE FORM

Information provided herein by you, the client, is confidential to the QEST™ practitioner working with you:

NAME____
ADDRESS______________________________________
CITY___________________STATE______ZIP_______
DATE OF BIRTH________________ AGE__________
e-MAIL ADDRESS______________________________

TODAY'S DATE_____________________________________
HOME PHONE______________________________________
WORK PHONE______________________________________
CIRCLE married widowed single divorced
SPOUSE'S NAME____________________________________
REFERRED BY______________________________________
IF CHILD, LIST PARENTS NAMES_____________________
OCCUPATION_______________________________________
Is it ok to send email newsletters?_______________________

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Please use page four if more space is needed

1. When you were born, was it a difficult birth? **Y N** Very rapid birth? **Y N** C-section? **Y N** Forceps? **Y N** **Comments**:

2. Have you ever had blows to the head? (Need **not** have caused unconsciousness) Examples: Fall from a bicycle or down stairs, car or sports accident, object hitting head, etc.) **Y N** Was a concussion diagnosed? **Y N** If yes, please list age(s) or year(s) and **describe what happened**. Be sure to describe any problems experienced afterward.

Have you or do you currently play sports? Were you raised on a farm or ranch? Do you or have you ridden horses?

3. Have you ever experienced a "whiplash"? **Y N** If yes, please say what happened and what you experienced afterward.

4. Have you ever had any fractures (broken bones), sprains, or other sports or auto accidents? **Y N** If so, please list with appropriate date(s) or age(s).

5. Surgeries? **Y N** Please list, with date(s) or age(s).

6. Have you ever experienced chiropractic manipulation? **Y N** Was for (circle): neck upper or mid back lower back other Are you currently receiving adjustments? **Y N**

7. Are you taking any medication? **Y N** Under doctor's care for any reason? **Y N** If so, please explain:

8. Are you receiving any other kinds of healing modalities? **Y N** Please list.

9. Describe your diet. (*Check the one(s) that best describe your eating pattern, and give details in the space below.*

__ heavy meat (all kinds)
__ light meat (all kinds)
__ eat chicken & fish only
__vegetarian (no meat)
__ vegan (no meat, eggs, or milk products)
How much water do you typically drink per day?_____ glasses
<u>List food in a typical day in the space below</u>:

10. Please indicate which of the following you are taking…and if possible, which brands:

__ vitamins	__ homeopathic remedies
__ minerals	__ herbs
__ antioxidants	__ phytochemicals / carotinoids (from plants)
__digestive enzymes	__ other

11. Do you use any of the following…please indicate amounts and frequency:

__ coffee	__ sugar
__ "sodas"	__ tobacco
__ alcohol	__ recreational drugs

12. Do you have, or have you ever had: (*Please check all that apply)*

__ measles	__ bronchitis	__ hepatitis	__ pacemaker
__ mumps	__ pneumonia	__ HIV or AIDS	__ cancer __chemo __radiation
__ chicken pox	__ rheumatic fever	__ herpes	__ vaccinations
__ scarlet fever	__ asthma	__ heart attack	__ screws, metal plates
__used antibiotics			

13. Do you have any allergies? **Y N**

If yes, <u>list</u> types & explain: foods **Y N** airborne **Y N** environmental **Y N** cats **Y N**

Do you have respiratory or sinus problems? **Y N** skin irritation **Y N** other?
Do members of your family have any allergies? **Y N**

14. Number of pregnancies_______ Number of children________ miscarriage(s) ________
Type of contraception (if applicable) ___________________________

15. Do you experience any of the following?

If so, please indicate: "A"=Always "F"=Frequent "S"=Sometimes

__headaches
__stiff neck
__upper back pain
__lower back pain
__sciatica (pain down leg
__hip pain
__ankle pain
__calf pain /leg pain
__foot pain
__heel pain
__elbow pain
__wrist pain
__tickling in throat
__periodontitis
__heartburn
__discomfort after eating
__intestinal gas
__abdominal distension
__intestinal pain
__diarrhea
__constipation
__rectal pain, fissures, bleeding
__hemorrhoids
__gallstones
__fatigue
__feeling of weakness
__light-headedness
__panic attacks
__anxiety
__feeling "on edge"
__feeling of impending doom
__depression
__hyperactivity
__attention deficit disorder
__learning difficulties

__hand pain
__chest pain
__pain in area of ribs
__pain in / behind sternum
__shoulder pain
__knee pain
__numbness / tingling fingers
__TMJ / jaw pain
__arthritis (joint inflammation)
__osteoporosis
__sinus congestion
__dental problems / cavities
__trouble focusing/thinking
__trouble sleeping
__tachycardia/rapid heartbeat
__high blood pressure
__very low blood pressure
__high cholesterol - LDL
__high triglyercides
__kidney stones
__bladder infection
__frequency of urination
__wake up at night to urinate
__difficulty urinating
__burning/pain with urination
__impotence
__swollen glands
__sore throat
__acne or skin break-out
__psoriasis
__cysts
__tumors
__many moles/warts
__frequent colds/flu
__bruise easily
__blood clots

__diminished sense of taste
__diminished sense of smell
__equilibrium problems
__ringing in ears
__pain in ears
__dizziness
__difficulty swallowing
__difficulty taking deep breath
__eye pain / dryness
__cough
__hungry right after eating
__stomach feels too full to eat
__diminished immune response
__anemia
__seizures
__PMS
__painful/abnormal periods
__painful abdomen
__parasites known/ suspected
__irregular periods
__menopause
__TGIF
__diabetes diagnosed/suspected
__craving of sugar
__low blood sugar
__more tired after eating
__coordination problems
__accident-prone
__tired of questionnaires
__chronic muscle pain
__joint pain
__frequent bloody nose
__other________________
__any reactions to prior energy work.
Please describe here:________________
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16. Current exercise. Please list type and frequency of exercise. Example: walking—daily; running—3 x week, swimming—1 x week, weights—3 x week, Pilates, etc.

CURRENT CONCERNS: (*Use back of page if needed!)*

What has prompted you to make this appointment? What are you most concerned about right now?
(Many people come to experience Quantum Energetics because they want improved energy, enhanced immune response and sense of well-being, and/or early detection / prevention of problems. If this is true for you, please indicate. (Note: no promises are made for QE.)

If you have specific problems, please list. For each, indicate when the problem started, any existing diagnosis and treatment. What has helped…or what has not helped? Please use next page as needed.

What would it mean to you to be free of these problems or…to have these problems diminished? i.e., how would it enhance the quality of your life?

What would you be able to do (and like to do) that you cannot do now?

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To the best of my knowledge, I have listed all of my past and current conditions. (or my child's)
***Signature*____ *date*____________________________________**