

**CLIENT INFORMATION FORM**

*This information form is to help maximize the benefits of our session together. After filling it out, please send back to us or bring it in with your first appointment. Thank you, and we look forward to seeing you!*

**Name:**

**Address:**

**City:**

**State/Province:                      Zip/Postal Code:**

**Home Phone:**

**Work/Cell Phone:**

**Birth date:**

**Time of Birth:**

**Birthplace: City/State**

**Email Address: (please check for accuracy)**

**Initial Questions:**

\_\_\_ **# of Organs Removed: (if all teeth = 1)** \_\_\_\_\_

\_\_\_ **# of Prescription Drugs**

\_\_\_ **# of Cigarettes smoked per day**

\_\_\_ **# of Steroid Drugs**

\_\_\_ **# of Metal Fillings**

\_\_\_ **# of Street Drugs**

\_\_\_ **# of Allergies**

\_\_\_ **# of Unresolved Mental Factors (greed, sadness, resentment, anger, etc.)**

\_\_\_ **I am responsible for my body: 0=no 10=yes**

\_\_\_ **% Fat in Diet (average is 45%)**

\_\_\_ **Personal Stress None=0 Max=10**

\_\_\_ **# of Sugar products per day**

\_\_\_ **# of Exercise sessions per week (20 minutes+)**

\_\_\_ **# of Alcoholic beverages per day**

\_\_\_ **# of Caffeine products per day**

\_\_\_ **# of Extreme Toxic Exposures per year (chemo, radiation, etc.)**

\_\_\_ **# of Major Traumatic Injuries in life (mental, emotional, physical- accidents, etc.)**

\_\_\_ **# of Major Infections in lifetime**

\_\_\_ **# of Glasses of Water you drink per day**

\_\_\_ **# of Pounds overweight**

**Please indicate any areas of interest or concerns for the Biofeedback session :**

**Personal incidents History:**

**Referred by:**

*Please note: We are not medical doctors, and, as such, by law, we cannot diagnose, treat, cure or prevent any psychological disorder or disease.*