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

CLIENT INTAKE FORM

NAME_____ TODAY'S DATE_____

CELL PHONE_____

HOME PHONE_____ WORK PHONE_____

CIRCLE married widowed single divorced

ADDRESS_____ SPOUSE'S NAME_____

REFERRED BY_____

CITY_____STATE_____ZIP_____ IF CHILD, LIST PARENTS NAMES_____

OCCUPATION_____

DATE OF BIRTH_____ AGE_____ E-MAIL _____

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Please use back page three if more space is needed

1. When you were born, was it a difficult birth? **Y N,** **A v**ery rapid birth? **Y N,** C-section? **Y N** Were forceps used? **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.

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. Blood Type_____

10. 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
List food in a typical day in the space below:

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

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

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

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

13. 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

14. Do you have any allergies? **Y N**
If yes, list 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**

15. Number of pregnancies_____ Number of children_____ miscarriage(s) _____
Type of contraception (if applicable) _____

16. Do you experience any of the following?
If so, please indicate: "A"=Always "F"=Frequent "S"=Sometimes

__headaches	__hand pain	__diminished sense of taste
__stiff neck	__chest pain	__diminished sense of smell
__upper back pain	__pain in area of ribs	__equilibrium problems
__lower back pain	__pain in / behind sternum	__ringing in ears
__sciatica (pain down leg	__shoulder pain	__pain in ears
__hip pain	__knee pain	__dizziness
__ankle pain	__numbness / tingling fingers	__difficulty swallowing
__calf pain /leg pain	__TMJ / jaw pain	__difficulty taking deep breath
__foot pain	__arthritis (joint inflammation)	__eye pain / dryness
__heel pain	__osteoporosis	__cough
__elbow pain	__sinus congestion	__hungry right after eating
__wrist pain	__dental problems / cavities	__stomach feels too full to eat

__tickling in throat
__periodontitis
__heartburn
__discomfort after eating
__intestinal gas
__abdominal distension
__intestinal pain
__diarrhea
__constipation
__alternating 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

__trouble focusing / thinking
__"fuzzy" headedness
__trouble sleeping
__tachycardia / rapid heartbeat
__high blood pressure
__very low blood pressure
__high cholesterol—LDL
__high triglycerides
__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
_____

__diminished immune response
__chronic fatigue
__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:

Are you right _____ or left_____ handed?

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 not helped? Please use back of page if needed.

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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_____