Date: _____

Healing the Quantum Way

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Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Place of Birth:**_____

Time of Birth:_____

Hm phone #: ( ) _____ Cell phone #: ( ) _____

Female _____ Male _____ e-mail: _____

Who referred you? _____ **Do You Have a Pacemaker?** _____

Number of organs removed		Rate your personal stress from 1 - 10	
Number of synthetic drugs used currently		Number of times you use sugar type products per day (including wheat)	
Number of cigarettes you smoke a day		Number of times you exercise per week 20 minutes or more –not work related.	
Number of steroid drugs used per year		Number of alcoholic drinks per day(ave.)	
Number of amalgam (silver) fillings		Number of caffeine products used daily	
Number of street drugs used per month		Number of past toxic exposures (chem., pest, radiation, chemo, etc.) per yr.	
Number of known allergies		Number of past major injuries	
Number of unresolved emotional factors		Number of past major infections	
I believe I am responsible for my body 1 – 10 (10 I am completely responsible)		Number of glasses of water per day	
Amount of fat in diet from 10 – 100%		How many pounds overweight	

Please check if you have or have had any of the following:

___ AIDS/HIV
___ Alcoholism
___ Allergy shots
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding disorder
___ Breast lumps
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___Chemical dependency
___ Chicken pox
___ Depression
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fracture(s)
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated disc
___ Herpes
___ High cholesterol
___ Kidney disease
___ Liver disease
___ Measles
___ Migraine headaches
___ Miscarriage
___ Mononucleosis
___ Multiple sclerosis
___ Osteoporosis
___ Parkinson's disease
___ Pinched nerve
___ Pneumonia
___ Polio
___ Prostate problems
___ Psychiatric care
___ Rheumatoid arthritis
___ Rheumatic fever
___ Scarlet fever
___ Stroke
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Tumor growths
___ Ulcers
___ Other_____
_____

Family History: Please indicate if any family members have had or have any of the following medical problems and if so who:

___ Diabetes _____
___ Hypertension _____
___ Stroke _____
___ Alcohol problems _____
___ Mental/Emotional problems _____
___ Heart Disease _____
___ Hepatitis/Liver disease _____
___ Cancer _____
___ Congenital problems _____
___ Other _____

Describe any concerns and your objectives in seeking services here:

_____
_____
_____
_____
_____
_____

Waiver of All Claims:

Nutritional Protocols obtained at Healing the Quantum Way serve as recommendations for clients to naturally support the bodies physiological and biochemical processes, and not to diagnose, treat, cure or prevent any disease or condition. There is no warranty or guarantee expressed or implied in the biofeedback, Acupoint Nutritional Testing and/or supplement protocols and products purchased. You are responsible for the outcome of your current habits and your commitment to health programs. We are here to support you in that endeavor, not to replace your individual and personal responsibility for your health. Some products recommended for clients have not been evaluated by the Food and Drug Administration. Always consult with your professional health care provider or Doctor before changing any medication or adding Vitamins or nutritional supplements to your regime.

Client recognizes there are risks of injury or bodily harm from any ingestion of products into the body from many different causes and the client expressly assumes all such risks and agree to hold Healing the Quantum Way and its practitioners harmless there from. The Client acknowledges and accepts the risks inherent in the use of nutritional products and/or biofeedback. In consideration of Healing the Quantum Way extending products & services, the Client agrees to waive all claims for any injury from any cause against Healing the Quantum Way, its agents or employees, and that Healing the Quantum Way shall not be liable for any injuries or be subject to any claim, demand or damages whatsoever, including without any limitation, those resulting from negligence on the part of Healing the Quantum Way or any of its practitioners or employees.

I understand that the attending practitioner(s) are not allopathic doctors (MDs) and do not portray themselves to be and are providing me with biofeedback and/or Acupoint Nutritional Testing services. Procedures used include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioner(s) do not offer allopathic drug, surgery, chemical stimulants, or any other conventional treatments. In addition, I will not receive a diagnosis, treatment, or prescription for my disease, condition(s), or illness, or have any act performed to me that would constitute the practice of medicine for which a license is required.

I have solicited the attending practitioners' services in good faith, exercising 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. I am fully aware and release the practitioner(s) to do Acupoint Nutritional Testing, biofeedback testing, wellness consultation and/or other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and that I am here on this and subsequent visits solely on my own behalf.

I have hereby read the above and confirm my understanding that services and product obtained at Healing the Quantum Way serve purely to provide nutritional support and/or stress reduction through biofeedback to my body, and are not a source for curing or treating disease. I also understand that it is my responsibility to obtain health care services as needed from appropriate practitioners including, but not limited to Medical Doctors, Chiropractors, Dentists, etc.

_____ _____

Signature of client (parent for minor) Date